MENTAL HYGIENE

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MENTAL HYGIENE AND RELIGIOUS TEACHING

H. FLANDERS DUNBAR, M.D., PH.D.
New York City

WHEN one considers the smothered, mutilated, distorted souls of numbers of religious people who gather in church to have read to them the words, "I have come that they might have life, and that they might have it more abundantly," one finds within one's self a vague sense that something has gone wrong. A general uneasiness concerning religion and religious teaching has diffused itself throughout the structure of our social life, to such an extent that not a few of those into whose keeping the house of the Lord was given are beginning to wonder whether it is already too late to check the vast army of doubts already imbedded like termites in its very foundation. What really is happening?

The twentieth century, with its development of mental hygiene, has shown us the importance of religious teaching in a new perspective. "It is hardly an exaggeration," said President Lowell on one occasion, "to summarize the history of four hundred years by saying that the leading ideas of a conquering nation in relation to the conquered was in 1600 to change their religion; in 1700 to change their laws; in 1800 to change their trade; and in 1900 to change their drainage." This places modern medicine, especially in the aspects of hygiene and public health, at the forefront of our civilization, comments Dr. Haggard.[1] But what is really significant is that among medical men to-day there is a renewed appreci-

[1] *The Lame, the Halt, and the Blind; The Vital Rôle of Medicine in the History of Civilization*, by Howard W. Haggard, M.D. New York: Harper and Brothers, 1932. pp. 4–5.

ation of the interdependence of psychic and physical factors in health. This appreciation is transforming our public-health program.

Modern medicine has brought about changes in our life of tremendous sociological significance. For example, the average length of life four hundred years ago is said to have been eight years,[1] and to-day it is in the neighborhood of sixty. But this question remains: If the average man to-day lives sixty years instead of eight, should he not have made a certain amount of progress in the art of living? Religions from time immemorial have occupied themselves with this matter. Religious teaching has been concerned with such questions as the meaning and aim of life and the relationship of the individual to the social group, including its traditions. Each religion has sought to offer a way of life.

Yet the question as to what makes life worth living remains, remains indeed as a symptom pointing to factors that we are coming to recognize as of vital importance to health. It is being asked daily by the thousands of sufferers from nervous and mental diseases who fill half of our available hospital beds, and it is being asked similarly by sufferers from organic illness. Physicians are beginning to consider as a serious element in their prognoses the presence or absence of the will to get well. What is it that makes it worth while to get well, to live? This age-old question is being asked to-day throughout our civilization, and that not only by those who are ill in bed. The question has been answered popularly in the words of the poet: "While men are free to think and act, life is worth living still." But what is it that makes man free to think and act?

Our civilization has sought to answer this question in several ways. It has sought to answer it through scientific inventions, which in the form of potentialities for thinking and acting have transformed the world with each generation. Two generations ago the number of people with whom one could exchange thought under normal circumstances was limited perhaps to the family circle and the neighbors. It was a great event if one met some one with a different back-

[1] *Mystery, Magic, and Medicine; The Rise of Medicine from Superstition to Science*, by Howard W. Haggard, M.D. New York: Doubleday, Doran, and Company, 1933. p. 29.

ground from one's own, from a distant city or a foreign country. Now with telephones, radios, railways, airplanes, each one of us comes into contact daily with more different people than many of our ancestors would see in weeks or months, or even years. Our civilization has sought an answer also in terms of more and more democratic government, and of laws aiming to give to each individual a maximum of freedom to think and act, and yet, surprisingly enough, most individuals seem to be strangely unable to take advantage of all these opportunities for thinking and acting. We have people becoming so much upset over the injustice of the social order that they seem scarcely able to think at all. We have those with the craze for power who build themselves machines, or buy them, and then become slaves to them, are maimed or killed by them, like the child who plays with an axe. We are coming more and more to realize that we are acting like children in a generation in which thinking and knowing is the great slogan, in which more of us go to college than ever before, and more of us travel and come into contact with the leaders of the world. Such are our achievements, but where is our freedom to think and act?

Those in whose hands we have placed the responsibility for our general health to-day have come to realize that it is emotion that makes us free or not free to think and act and that careful scientific attention to our emotional life is as much needed as attention to our drainage. Health officers have come to realize that their program must include not just medical groups, social workers, leaders of industry, and those in control of public works and housing conditions, but also, and even primarily, parents and teachers, including our teachers of religion.

"On the shoulders of the clergyman, whether he realizes it or not, rests a fundamental responsibility for the mental hygiene of his community."[1] Not only is he consulted by numbers of people who are entirely unaware that what they really need is medical attention, but also he has "a peculiar vantage point in that people look to him for standards, goals, and ideals."[1] The term "health" is coming now to "include

[1] *A New Opportunity in Theological Education; A Description of the Policy and Program of the Council for the Clinical Training of Theological Students*, Revised and Approved for 1934. p. 4.

sanity of beliefs as well as soundness of body."[1] We have come to realize that even in terms of our day the seventeenth century was far from unenlightened in its emphasis on the changing of religion.

This is all part of the physician's realization that in the development of any public-health program, both physical and mental factors must be included. Health of either body or soul involves the health of both. As we go forward to-day, evolving out of the nineteenth century with its emphasis on drainage, and thinking in terms of changing the emotional life of our people, we are asking questions of religion.

The teacher of religion, be he parent, teacher, or clergyman, is only too likely to forget his setting, to think in terms primarily of subject matter and teaching method. But religion is not primarily an academic discipline. We all talk loosely about religion. Some of us in using the word mean a system of dogmas and beliefs; some of us mean a special way of life, or practices, or morals and ethics; and some of us mean *Weltanschauung,* a word with no English equivalent, meaning one's attitude toward the universe in terms of emotion, intellect, and volition. Those who attack religion are usually vague as to exactly what they are attacking, and the same can be said for those who plead its cause. The teacher of religion, however, is too likely to think only of the system of dogmas and beliefs, and to forget that even in teaching these, he is presenting a way of life. Occasionally he realizes this, but it becomes a problem. In presenting principles of individual and group conduct, he is often unaware of the extent to which he molds lives, contributing to the health or disease of the individual or of the social order.

The following case history, in which the patient's own words are given in paraphrase, will make the situation more concrete.

> James Roe, aged seven, was the model boy in the Sunday School, and the pastor's pride and joy, to say nothing of his mother's. He always sat on the front row with folded hands, a pattern of Christian precepts, to be pointed out to the bad boys, who laughed and poked fun at him as well as at the teacher. He had never been known to disobey; rarely had he been known to do anything on his own initiative without asking

[1] *Delusion and Belief,* by C. Macfie Campbell, M.D. Cambridge, Mass.: Harvard University Press, 1927. p. 5.

for permission; and he very seldom did anything anyway unless he was told to do it. James had found that when he did things the other boys did, he was only too likely to do something inexplicably wrong, and then the widowed mother, who often told him that he was all she had in the world, would cry pitifully. He would never forget how, on one of these occasions after he had run away, the pastor took him to his study and told him what his dear saintly mother had lost in the death of that splendid man, his father, and what a lot he had to live up to, and for how much he must make up to her.

So James had decided that the safest way was to do all his adventuring in his own mind, since that could disturb no one. He built himself castles and rescued forlorn maidens to his heart's content, sitting demurely at his mother's side when her friends came in to call. He knew he was good, the best boy in school; his teacher had often told him so. He began to wonder if God had intended him for some great destiny, like the prophets in the Old Testament.

When James was fourteen, the small income his father had left was mismanaged and swept away. The course of study to which he had devoted himself feverishly in preparation for his mission (too feverishly, as it was said about town, because, for all his brains, James was a delicate boy) was rudely interrupted because on his shoulders devolved the responsibility of supporting his mother. The pastor, his constant friend and adviser, talked to him about the discipline of the Cross, and the Christian character that is gained through disappointment. But James somehow couldn't understand why God, Who had destined him for such great things, should now force him away from the studies he loved into the high-pressure life of self-seeking and competition, where all the Christian precepts seemed to have been replaced by the maxim "the devil take the hindmost," where an oath or a crude joke would open more doors than any amount of brotherly love. He found himself a sort of laughingstock because of his gentle ways; but then Christ, too, had been scourged. Somehow he wasn't succeeding. He lost one job after another, and he couldn't bring his mother home enough to eat. He thought of God and that splendid man, his father, and wondered if it could be that he had failed. The pastor continued to speak to him of Christ, but he felt only a gnawing sense of failure—and then something cracked in his head. Later, in the mental hospital, he told the superintendent that he was Christ, and rather incoherently threatened him with damnation or pleaded for freedom. Somehow he "couldn't make them understand." It was too late for them to help him.

This story has very little that is unusual about it. The striking thing is that we are only just coming to realize that we have here a problem that deeply concerns the future of our civilization. The people about town thought it was overwork that sent James to the hospital. They would scarcely believe it if they were told that overwork in the absence of emotional conflict never sent any one to a mental hospital, and that in this case it was to a considerable extent the pastor himself

who quite unwittingly drove James there.[1] All the remarks that are to follow concerning religious education could be related to this case history. Here and there attention will be called to the fact; here and there, because of limitations of space, the application will be left to the reader.

One could tell story after story illustrating the same point—homes sacrificed to the care (honor) of ailing father or mother-in-law, and the many other tragic results of devoted obedience to false religious standards and ideals, to say nothing of the hidden fear and secret guilt that haunt the eyes of so many religious people, who feel that in some way they have trespassed against the God of their fathers, or the hatred and defiance in the eyes of others who feel themselves in some way betrayed, bound, or smothered by that which they had been taught to respect and love.

A dramatic example of this was presented to us not long ago in *The Barretts of Wimpole Street.* There one saw the favorite daughter of the Puritan father confined to her bed and forced bit by bit to relinquish her hold on life itself by her love for her father and his love for her. One can scarcely fail to grasp the deep unconscious significance of his prayer at the foot of her couch:

> "Almighty and merciful God, hear me, I beseech Thee, and grant my humble prayer. . . . For years [Thy daughter Elizabeth] hath languished in sickness; and for years, unless in Thy mercy Thou take her to Thyself, she may languish on. Give her to realize the blessed word that Thou chastisest those whom Thou lovest."[2]

This prayer is all the more cogent in that it follows directly on the scene of the tankard of porter which Elizabeth at first had refused to drink. We have Barrett's fierce reproach:

> "You're not frightened of me. No, No. You mustn't say it. I couldn't bear to think that. You're everything in the world to me—you know that. Without you I should be quite alone—you know that, too. And you—if you love me, you can't be afraid of me. For love casts out fear. . . . You love me, my darling, You love your father?"

[1] For a discussion of this case history in terms of the pastor's techniques, see *Clergyman, General Physician, and Psychiatrist. How Should They Work Together?* by H. Flanders Dunbar, M.D. (A paper of the 1934 Church Congress.) Milwaukee: Morehouse Publishing Company, 1934.

[2] *The Barretts of Wimpole Street; A Comedy in Five Acts,* by Rudolf Besier. Boston: Little, Brown, and Company, 1933. p. 33.

Then, after Elizabeth's whispered "Yes," Barrett pushes on:

"And you'll prove your love by doing as I wish?"

Elizabeth hesitates:

"I don't understand. I was going to drink—"

But he interrupts her:

"Yes—out of fear, not love. Listen, dear. I told you just now that if you disobeyed me, you would incur my displeasure. I take that back. I shall never in any way reproach you. You shall never know by deed or word or hint of mine how much you have grieved and wounded your father by refusing to do the little thing he asked."

Elizabeth: "Oh please, please, don't say any more! It's all so petty and sordid. Please give me the tankard."

Barrett presses relentlessly:

"You are acting of your own free will, and not—"

And Elizabeth can only say:

"Oh, Papa, let us get this over and forget it!"[1]

Then we have Barrett at the end of the play:

"Do you know that night after night I had to call up all my will power to hold me from coming here to forgive you?"

Elizabeth: "Papa—"

Barrett: "All my will power, I tell you—all my sense of duty and right and justice. . . . But to-day I could bear it no longer. The want of your face and your voice became a torment. I had to come, I am not so strong as they think me. I had to come. And I despise myself for coming—despise myself—hate myself."[2]

And then came the story of the love of his wife, Elizabeth's mother, which turned into fear, because he did what he knew was right. Many lives have been shipwrecked in the last decades by conscientious people who, with the support of their clergymen, have done "what they knew was right."

And religion is potent in the direction of health or illness, not just as it sets standards, but particularly as it influences emotions. Anthropologists tell us to-day—and history has recorded—the story of religion as a technique devised by man, or given by God, for the handling of emotional life, particularly those emotions involved in the relation of the individual

[1] *Loc. cit.*, pp. 31–32.

[2] *Loc. cit.*, pp. 151–152.

to the group, our loves and our hates, our fear and our guilt. Perhaps it is for this reason that certain clergymen whose attention has been turned to problems of health to-day are inclined to call nearly everything religious that is effective in the sphere of emotions. Yet there has been little consideration of religion from this point of view.

The attempt to defend the importance of religion by means of fragmentary utterances made by physicians and psychiatrists concerning the importance of emotion in health and illness is unfortunate, because usually the aim is to derive support for a traditional position rather than to develop that position in the light of what we know to-day. In spite of the new interest in the findings of biology and psychology, there has been very little attempt to assimilate them. Relatively little is said about emotional development in textbooks concerning religious education. Little is said about religion in relation to health and full adult living, involving an adjustment to the universe and to men.

There are two trends in religion to-day, especially in religious education. There is a mechanistic trend expressed in terms of the early development of habits and the right conditioning of a child's acts, where the favorite analogy is Pavlov's dogs and emotions are given little or no consideration, although a great deal is said about the learning process. On the other hand, there is the attempt to use a combination of love and fear as we see it portrayed in Barrett, Senior. Steering more or less a middle course are those who express everything in terms of attitudes. Unfortunately this term is usually a cover for a good deal of loose thinking divorced from knowledge of the laws of biology and education on which the development of satisfactory attitudes depends.

We know now that a primary law in instinctive development, from infancy to adult life, is that excessive thwarting or excessive gratification of any primitive need is a block in development. As Alexander has said: "So long as society's methods of adjusting the child's ego to collective life remain either intimidation and deprivation, or spoiling (instead of a scientifically founded, adequate combination of both) criminality will be an unavoidable by-product of social life."[1]

[1] "The Relation of Structural and Instinctual Conflicts," by Franz Alexander, M.D. *The Psychoanalytic Quarterly*, Vol. 2, April, 1933. p. 207.

This is a matter of fundamental importance to parents and to religious educators, who are likely to become involved in one way or another in the child-parent relationship. But this is only one example. Teachers of religion have given relatively little attention to religion as a technique for the handling of the emotional life of the individual in relation to the group, involving evaluation of the ideal and the real.

As religious educators begin to turn their attention to these things, however, attempting to become familiar with the laws of biological development, physical, mental, and spiritual, they find themselves embroiled in a number of theological concepts involving sin and free will or responsibility which are so difficult to manage that the tendency is to try to forget them—to occupy themselves with what they call the practical, leaving problems of theology for the pastor to grapple with on Sunday. But many of those whom they are teaching hear the pastor preach on Sunday, and sometimes even read their Bibles, and are disturbed.

A very simple illustration, to which one cannot refer too often, is the difficulty that results from an inadequate handling of the symbols through which concepts are often expressed to the people. It is noteworthy that "a great many people to-day are giving up religion either because it seems to them ridiculous to believe that God is anthropomorphic—an old man with white hair sitting above the clouds—or because they have a deep hidden resentment against the tyranny of their own fathers which makes it impossible for them to pray 'dear Heavenly Father' with any sort of comfort. They fear or resent in the Church a continuation of parental authority—or long for it."[1] The group of people who use the church as a way of avoiding responsibility need special attention. They constitute a practical problem to handle which the teacher of religion must know something of the resources of the community and how to use them.[2]

Space does not permit a discussion of the problem of authority in relation to problems of dependence and fear.

[1] For a discussion of the dynamic aspect of symbolism in relation to the concept of the sacramental life, etc., see "The Faith and the New Psychology," by H. Flanders Dunbar, M.D. *The Living Church*, January 13, 1934. p. 336.

[2] Cf. *A New Opportunity in Theological Education, op. cit.*

The history of Christianity is full of illustrations. We see in the various heresies, and particularly in the sects, beneath brilliant intellectual formulations the emotional reactions of the adolescent boy claiming his independence, his right to think for himself, and setting out to reform. We see similarly his inability to become free, his looking back longingly, or turning back and yielding himself again to the wisdom of the fathers. This is a subject of such importance that one cannot refer to it casually in passing without running the risk of being misunderstood. One can, however, suggest a study of this problem in the light of what we know of emotional development to-day. Through careful handling of symbolism much may be accomplished here. This will do no injustice to the multitudes of neurotics who find their haven within the church. These people will interpret its symbolism in accord with their neuroses no matter what they are taught, and need no encouragement to do so. On the other hand, encouragement in a more adult interpretation of the symbolism may lead them gradually to more adult levels of living by way of the only language that they can understand.

The religious educator needs, then, not only a dynamic understanding of symbols—that is, of the impulse to symbolize as it may subserve the interests of health or illness—but also a dynamic understanding of religious concepts themselves. Again space permits only a crude example. The God of the Old Testament and the God of Puritanism is often presented as a God of wrath and vengeance; men who patterned themselves after Him found great encouragement and scope for the development and exercise of aggressive or cruel impulses (sadism). The God of the New Testament has been portrayed as a God of suffering; personalities patterned after Him have found equal encouragement for any tendency they might have toward self-depreciation and self-torture (masochism). (Incidentally, this latter is a tendency that is much more dangerous than is usually realized because it may be part of a process leading on the one hand to serious mental illness and on the other to suicide.) These Gods are often played off against each other, but the distortions produced through overemphasis in one direction or the other contribute toward the development of sick personalities rather than

toward health. Here, again, we find theological concepts assuming deep practical significance.

Protestant literature abounds in such statements as the following: "Morals and religion undergird good citizenship upon which the permanence and high quality of the nation depend."[1] The usual theistic description of God in this connection is that of controlling cosmic power possessing personal attributes of rationality and goodness, and interested in human values, Who imposes upon men certain ethical requirements,[2] thus making them good citizens. In other words, He is a sort of monitor (or projected super-ego) shaped by the experiences of the child with his father. (Stories of human lives are full of instances in which faith in God was lost because of His failure to punish or reward.[3]) In so far as He is emotionally effective in determining conduct, this sort of God is effective through the medium of emotions following the childhood patterns. Yet we know it is only through the freeing of the gradually developing emotional life

[1] "Historical Development of Religious Education in America," by Dean Karl R. Stolz. *Studies in Religious Education.* Nashville: Cokesbury Press, 1931. p. 50.

[2] See Dr. Georgia Harkness' "An Underlying Philosophy for Religious Education." *Studies in Religious Education.* p. 59.

[3] A discrepancy of this sort between ideals of divinity and the sordid reality of the human beings who preach such ideals puzzled Dinny Brumm, aged thirteen, the hero of Lloyd Douglas' novel, *Forgive Us Our Trespasses* (Boston: Houghton Mifflin Company, 1932).

> "Adversions and appeals to Deity were," according to Dinny, "merely an unscrupulous and unsportsmanly method of having your own way in dealing with people who might be so weak-minded as to believe that you and God were at one as to the soundness of your cause. If you couldn't get what you wanted out of the other fellow by wheedle and whimper . . . you bade him listen while you took it up with the Lord in prayer. . . .
>
> "Dinny no longer took any stock whatever in prayer—either in the family-worship kind of prayer that besought the Almighty to make you sweet-spirited and obedient to His Holy Will, five minutes after you had stubbornly objected, at breakfast on Saturday, to spending the whole afternoon helping Old Mullins clean out the church furnace, when you had been looking forward all week to a bit of carving on a fire screen; . . . or in the public kind of prayer that asked God to touch the generous hearts of this dear people." (pp. 77–78.)

Sometimes Dinny had qualms of conscience that he had "quenched the Spirit" by such sentiments as these and had committed the "unpardonable sin" his foster father talked about and warned his flock against. Dinny, however, was cynical at thirteen about religion and religious people because God never seemed to do what the minister said He would do.

from childhood patterns that healthy adult life and the prerequisites of good citizenship in a healthy social order are attained. Of course there are concepts of God at once less bald and less naïve than the concept first cited, but these concepts also only too often are taught or conveyed in a way that encourages the persistence of infantile patterns and the development of illness.

Again, a great deal has been said about our selfishness and hedonism, and it has been urged that our children be taught to follow the way of the Cross. But the way of the Cross, taught with this emphasis, only too often leads to the mental hospital, as it did in the case of James Roe. In other words, this is a concept which has been stressed in terms that lend themselves to neurotic elaboration in the direction of excessive cruelty on the one hand or self-torture on the other. The child's real problem is the replacing of lesser by greater good (as we find it expressed in early Christian thought and beautifully set forth, for example, in Dante's great poem of the Middle Ages), not merely in terms of the learning process, but in terms of adjustment of his emotional needs to the privations demanded by his culture. There are things that he wants (impulsively) to do, and there are things that he really wants to do after he has considered the extent of his ability and the probable results of his action in terms of his life situation. As he comes to live in these terms, he becomes free emotionally to grow in the direction that will give the greatest satisfaction and fullest development of the normal emotional life possible in our culture, thus eliminating much of bondage to love or fear. Lives developing in this way could be more truly "Christian." The concept of *God imposing* ethical standards and the long lists of "don'ts" become unnecessary. Similarly the rituals devised for the handling of guilt and fear might become less and less necessary. Thus organized religion might cease to be a sort of police system subject to bribery by those very tendencies which it aims to control, and might become instead a medium of expression for full creative lives.

These are matters that deserve special study on the part of educators in religion, but they cannot be studied in the abstract. They must be investigated on the basis of intensive study of, and experience with, human beings individually and

in groups. In such a study, furthermore, close coöperation with other specialists in human problems is exigent.

Religious education can be developed in its mental-hygiene aspects only when clergymen themselves are given training in the handling of human problems. Because it is important that there should be harmony and understanding between clergymen and those who devote themselves specifically to the problem of religious education, I shall point out certain defects in the clergyman's training which make it difficult for him to develop an intelligent program of religious education.

The clergyman, like the teacher of religion, must familiarize himself, not only with theory and theology, but, even primarily, with the behavior of individuals and groups in the world to-day. Until he does this he will have no basis on which to develop his teaching program in our twentieth-century perspective of preventive medicine and mental hygiene. Such hints as those given in the preceding section he will not be able to assimilate, however enthusiastically he may try to do so, and his adoption of biological and psychological vocabulary will only increase the split within him in his attempt to present on the one hand a subject matter, and on the other a way of life.

We are living through a period of hard times to-day, a period of unrest throughout our social order, because our mastery of nature has progressed by leaps and bounds, far outstripping our ability to manage human nature. So marked is this that our leaders are beginning to urge that our various scientists be given training in the handling of human nature and human problems. Secretary of Agriculture Wallace, for example, among others, pointed out recently that the engineer becomes absorbed with inventions, which if he be at all altruistically inclined he pictures as bringing great benefit to mankind, machines to save them from weary hours of toil, etc. He rarely pauses to study people sufficiently to know whether they will be able really to use the machines to save themselves toil, until perhaps there is brought rudely to his attention the fact that the inventions which he expected to be of great benefit to the people have become instead a powerful force in disrupting the social order. Wallace says:

> "The days when wheat was broadcast by hand, perhaps from a saddle horse, in retrospect seem quite romantic, but to the farmer who had to spend *days* at seeding-time where he now spends hours, the romance probably wore pretty thin . . . it didn't leave much time for living. The engineers and the scientists have given us instruments and methods whereby we can escape much of the grind; theoretically, there ought to be far more time for living and far more with which to enjoy life. Yet the reverse seems to be poignantly true."[1]

He also notes that although our scientists and inventors to-day have enough that is new within their grasp to double our wealth-producing power in the next generation, it is nevertheless quite likely that our wealth-producing power a generation hence will be less than it is to-day.

> "The trouble, if it comes, will not be in the inability of scientists and technologists to understand and to manage nature, but in the inability of *man to understand man* and to call out the best that is in him."[1]

The application of the scientific method to the problem of the universe around us has increased our range of possibilities a thousandfold. It is doubtful whether it has increased the sum total of our happiness or effectiveness as human beings. Our governors and our economists find themselves thwarted and their best-laid schemes going wrong because they have inadequately considered or controlled the distinctly individual human factors. The application of the scientific method to the study and control of human behavior must progress rapidly enough to keep man from destroying himself by the fruits of his own achievements.

There is a characteristic that the professional groups have in common—a tendency to focus their attention on the profession, forgetting those on whom the very profession itself depends, those whom as professional men they serve. Even the clergyman, whose very calling demands an understanding of his people, following the traditions of his profession, rather than the varying pulse of his people's life, may find himself doing something quite different from what he intended to do. And very often in later years he comes to himself strangely hurt because his people seem not to understand him. All of his intended service seems only to have estranged him from

[1] "The Social Advantages and Disadvantages of the Engineering-Scientific Approach to Civilization," by Henry A. Wallace. *Science*, Vol. 79, January 4, 1934. p. 2.

them. The trouble often is that he has given service according to the tradition of his calling with insufficient regard for the psychological development of his people.

Recently, in an article on medical education, I came across the following paragraph which offers a valuable suggestion:

> "A priest is said to be a man of God. But a physician is properly a man of Men. He must live with them; work with them; fight with them; crawl, walk, and run with them; go down to the slime pits and up to the mountain tops with them; know the stench of their bones and the blossoms and music of their souls, and accept them. Only thus can he learn neither to fear nor despise anything they may do or be. Only thus can the doctor apprehend the nature and languages of men."[1]

Strange as it may seem to those familiar with the traditional relationship of the priest to his community, this doctor implies that the priest, being a man of God, need not do any of these things. The idea of the clergyman as some one who remains in the sanctuary apart from men, studying scripture and doctrine, has been responsible for no small amount of his spiritual alienation, not only from his actual parishioners, but also from his potential parishioners in the community. This is the more important because it is responsible also for a large part of the harm he does in his nurturing of sick rather than of healthy personalities. There are those who look to the distant ideal which the clergyman presents and seek to pattern themselves after it. And if the truths promulgated by the clergyman are either out of accord with life to-day or too readily capable of distortion, he will find himself misleading to the extent to which he leads at all, as was illustrated earlier in this paper. All of this has its significance, too, for teachers in religious education.

Clergymen and teachers of religion are awakening to this situation, and are coming to appreciate the fact that their task, which involves the presentation of a way of life, including goals and standards, involves also a fundamental responsibility for the health of their community. They have realized that this responsibility cannot be fulfilled even as concerns the soul without thinking to some extent at least in terms of the emotional life and general health of those in their charge.

[1] "The Education of a Physician," by George Draper, M.D. *Journal of Nervous and Mental Disease*, Vol. 76, November, 1932. p. 452.

With this realization has come an enthusiasm throughout the seminaries of our country for training in mental hygiene, psychology, and psychiatry. The clergyman has felt himself lacking, especially the younger clergyman and students in the seminary. They have felt that other specialists in human problems were possessed of superior techniques. The more radical among our seminaries give courses in abnormal psychology and psychiatry, but without giving the student opportunity for adequate contact with the human being whose problems he is discussing. For this reason it remains an open question whether such courses do more harm or good. To remedy this defect field-work courses are being given increasingly serious attention, but they have remained fragmentary, and fragmentary experience of human beings leaves the clergyman in a situation analogous to that of the doctor who treats his patients in terms of a knee named Jones, and a heart named Rutherford. The heart or the knee may be interesting, but physicians realize to-day that neither one has much meaning and that neither one can be effectively treated without an understanding of the personality to whom each belongs. Similarly the youth as he appears in Sunday School and the boys' club, and the lady as she receives the minister, are only fragments of the total lady and the total boy. Such understanding of people as the clergyman needs is obtained only through living with them through long years of pastoral experience, and even then, we are coming to see, less satisfactorily than by living with them in a controlled setting, working together with other specialists in human problems, such as the general physician, the psychiatrist, the laboratory man, the social worker.

It was in order to give clergymen this opportunity that the Council for the Clinical Training of Theological Students was organized. This is not the place to outline the work offered by the Council.[1] But such training should be considered seriously, not only by clergymen, but also by directors of religious-education programs. It should be noted that the Council was established not just to give clergymen and religious educators opportunity for training, but particularly

[1] *Cf. A New Opportunity in Theological Education, op. cit. Cf.* also *The Faith and the New Psychology,* by H. Flanders Dunbar, M.D., *op. cit.*

to give them a general orientation that will safeguard them from the present-day furor in the direction of abnormal psychology and popularized psychoanalysis, so-called.

Our educators recognize to-day that their great weakness in dealing with American youth is not in the handling of intellects, or even of physiques, but in the handling of emotions. Religious educators share in this weakness, the more disastrously in that they are presenting, not primarily an academic discipline, but a subject matter for which they claim significance primarily because of its application to life in the handling of emotions, and principles of conduct, joys and griefs, and ideas of right and wrong. Only those who have lived among people, and among the various specialists in human problems who have developed techniques to help people, can give to the religious-education movement the significance possible in the light of present-day mental hygiene.

We are living in a culture full of tragic and jarring imperfections. This culture has been created through centuries of struggle for life. Our gradual progress in the mastery of and adjustment to nature necessitated our banding together. This fact has introduced serious complications into our relationships to one another. Religion comforted man's anxiety in the midst of what looked like chaotic nature, and to religion was given the task of enforcing (and later of helping governments to enforce) principles essential to the maintenance of our group life. More than this, religion offered a solution of inner conflicts arising out of man's endeavor to work out his relationship to the universe and to his fellows.

Our culture has presented medicine with many of its most difficult problems. We have had to learn the relationship of crowded living and improper housing conditions to tuberculosis. Our public-health officers, acting through our governments, have sought to remedy these conditions, acting from the outside. Their ability to do this is definitely restricted both by our instinctive nature and by our actual resources. In the state of the world's resources to-day, there is a limit to which conditions productive of illness, both physical and mental, can be remedied by bringing about alterations in the external world. We must work also with man's inner world, the world of his emotions and his goals.

And so modern medicine, in so far as it stands at the fore-

front of our civilization, is reaching out a hand toward all those other specialists in human problems without whose aid it must remain relatively ineffective. As physicians themselves are devoting more attention to psychic factors in illness and health, they are becoming more and more interested in those factors in man's environment which play on and mold his inner world and in those specialists, among them teachers of religion, who through the centuries have dealt with and given expression to man's inner life. Mental hygiene has done a great deal to awaken these other specialists to their rôle in preventive medicine. Mental hygiene itself, often defined as "a mosaic of aspects of the so-called pure sciences, medicine, sociology, anthropology, education, social case-work," etc., is coming to stress more and more the rôle played by the emotions in personalities and in our social order. Hence our need for a reconsideration of religion as a way of life, a system of beliefs, and as a *Weltanschauung,* in the light of mental hygiene.

We are trying now to educate parents in the simple laws of mental and physical hygiene. Their teaching of religion should be imbued with this knowledge and brought into harmony with it. Religion has always faced the problem of man's adjustment to his environment in terms of his culture and of the universe at large, and for this reason every religion has set forth its ideal hygiene program and at the same time its technique of adjusting to the privations that culture requires. Our teaching of religious hygiene (including mental and physical) should not be restricted to the laws set down in the Old Testament, unmodified by the changes in our civilization, and our increased knowledge and facilities.

Religion, in its task of guiding men in their adjustment to their total environment, outer and inner, begins with the infant, whose mother, as she is differentiated from himself in his experience, exists still like his own body, something to be commanded and to subserve his pleasure. As he becomes conscious of the "other" than himself, conflict arises. With conflict there comes the question, "Why?" And we might observe here in passing that "why" is so prominent in the vocabulary of the growing child, not merely, as we like to think, as evidence of his intellectual curiosity, but even primarily as evidence of protest. Why this "other," this out-

side world of increasing complexity which seems indifferently and unreasonably to thwart and hurt him or to caress him and give him joy?

The child is able at a very early age to distinguish the type of truth or reality that is subject to verification by the scientific method and the type that is not. In his religious teaching, in the answering of his "whys," these two should not be confused. Such confusion may seriously handicap his gradually developing intellect and thereby limit also his ability to handle his emotional life or to live religiously in the truest sense of the word. More important than this, it will provide him with emotional problems. When he discovers that he has been deceived or mistaught, his security and his trust will be threatened and he will find himself angry and resentful toward those whose friendship and support he most needs.

More than this, he who is educated religiously must be taught honestly about the nature of his fellow men. In a protected home or in Sunday School, the child too often gains the impression that other people, or "grown people," obey the precepts he is taught. It has been said: "Sending the young out into life with such a false psychological orientation is as if one were to equip people going on a polar expedition with summer clothing and maps of the Italian lakes."[1] Much less harm would be done were the religious educator to say quite frankly: " 'This is how men ought to be in order to be happy and make others happy, but you have to reckon with their not being so.' Instead of this the young are made to believe that every one else conforms to the standard of ethics—*i.e.*, that every one else is good. And then on this is based the demand that the young shall be so, too."[1] We see here another of the major errors in the educational influence to which James Roe was subjected. Had he been less protected and in a sense less of a model boy, it is possible that he might have surmounted the vicissitudes of his life instead of going under in the real world of to-day.

To the individual who has become conscious of an environment with which he must enter into relation, there are possible but three courses or attitudes: that of open rebellion

[1] *Civilization and its Discontents*, by Sigmund Freud, M.D., LL.D. Authorized translation by Joan Rivière. New York: Jonathan Cape and Harrison Smith, 1930. p. 124.

and the attempt to subject his environment to himself; that of coöperation accompanied by an attempt to understand the nature and aim of that which he feels to be outside himself; or, finally, that of evasion and escape. It is the task of the religious educator to assist the child in his development toward a consistent attitude of enlightened coöperation. This no teacher is able to do who is too much confused and too full of problems.

Teachers of religion should know themselves sufficiently to be somewhat aware of what they are actually doing—what they are teaching, and in what way they are molding personalities. Teachers in religious education and candidates for the ministry, not only should have much more practical training in the handling of human problems than they have at present, but also should be chosen more carefully. The teaching of religion involves far greater responsibility than the teaching of any one of the more intellectual disciplines in art or science. A warped or distorted personality, whatever the charm, ability, learning, or intelligence, should never be entrusted with the task. Such a person will inevitably live out his neurosis in his teaching and infect his students with it quite as seriously as if he sat down among them with a case of active tuberculosis. We see examples of this occasionally even among teachers of the academic disciplines, but here it happens accidentally or incidentally. The teacher of religion comes into inevitably telling contact with his pupils because his primary task, having to do with a way of life, predetermines to a great extent the general hygiene of their lives.

Finally, it is perhaps worth while to stress the fact that any discussion of mental hygiene and religious teaching must remain somewhat general and unsatisfactory until more work has been done in this field by those trained in religion and in the understanding of people (including their own personalities). Each teacher of religion, however, should study the development of the emotional life (not merely the learning process) sufficiently so that in his teaching of religion those elements in its symbolism and concepts which are consistent with adult living are emphasized, rather than those which encourage the persistence of infantile patterns.

GROUP TRAINING IN THOUGHT CONTROL FOR RELIEVING NERVOUS DISORDERS

WINFRED RHOADES
Shirley Centre, Massachusetts

A MAN who suffered from years of sickness, as well as other hindrances to success, used to play with the idea of finding a new kind of efficiency engineer who might help maladjusted people to turn personal disaster into personal success in the job of living. "That is what one's doctor might be," he wrote once, "if one could live with him constantly during the period of need." Such a doctor, he thought, would teach that art which is basic, the art of thinking straight—thinking straight about life, and about self, and about how to bring the two together in a more satisfactory way.

An effort at efficiency engineering of that kind has been going on during the last five years and more at the public dispensary in Boston. Every Thursday morning women and men who are in desperate need of help in adjusting their minds to the facts of life make their way to that place from all parts of the city, and from the suburbs as well. From tenements, from larger apartments, from houses that were once expensive holdings, from the little old frame dwellings of which Boston still has so many, from crowded sections and from scattered districts they come. As many as forty patients, in addition to doctors and secretaries and visitors, may gather together in one of the lecture rooms.

They are the victims of conflicts and complexes, these men and women. They do not think that themselves, at the beginning. They think that they are simple cases of digestive troubles, headaches, constipation, insomnia, tormenting pain, heart disorders—such ailments as those. But the expert doctors of the dispensary staff have found that they are not simple cases of physical malady. They are, essentially, cases of psychic maladjustment of some kind—cases of unreconcile-

ment to life. Even should it be true, as some think,[1] that in every psychoneurosis there is some obscure "fundamental physical error," possibly some "biochemical error," what these patients need most of all is not drugging, not electricity, not surgery, not infra-red rays or any such thing, but reëducation intellectually and emotionally.

Mrs. Sartonelli, for example, had been sick five years and, she says, "was a nervous wreck." The ticking of a clock, the sound of running water, the rattling of dishes, the noise of children—little things like those she simply couldn't stand. She cried a great deal. She couldn't sleep. She wished she were dead. If some one rang the bell or knocked at the door, she would not respond. She hated even her own self.

"Now," she says, "nothing gets me upset. I love to have friends and to meet them. Everything feels new. I take things easy and let work go undone. Things don't get any better if you worry. I now really enjoy life. I love to walk and to work. I walked over from South Boston this morning. I am going to a gym to reduce. I have had troubles. My daughter hasn't been working, and my husband hasn't been well for some time. But I just take things easy. I get courage and take hold of myself. I feel so different!"

Mrs. Sartonelli's intelligent young daughter, in a thoughtful statement given at another time, bore witness to the genuineness of her mother's improvement.

A study of case records at the Boston Dispensary had shown that approximately one-third of the people who came to the medical clinic for help were, like Mrs. Sartonelli, not primarily cases of organic lesion at all; or, if there was some actual physical derangement, that it was not sufficient to account for the symptoms and the suffering. Yet these folk were none the less sick, none the less in distress. Even if no known physical treatment could make them well, they none the less needed help. They were (as the doctor is fond of telling the group) like Plato's chariot, pulled in diverse ways at the same time by the black steed of passion (emotion) on the one hand, and the white steed of reason on the other. Repressed, unresolved complexes and conflicts were at the

[1] Dr. T. A. Ross may be cited in this connection. See his *Introduction to Analytic Psychotherapy*. New York: Longmans, Green, and Company, 1932. pp. 198–99.

bottom of their symptoms. The pains were real enough; the gastric and intestinal disorders were real; the nausea, the palpitation, the tremor, the paralysis were all real experiences. But they were functional and not organic. Their initiating cause was unhealthy emotional life, and not unhealthy tissues and cells.

During the last forty years psychological treatment in its various forms has gained a definite and important place in scientific medicine, but in the main its practice has been confined to those who could afford to pay for hours upon hours of the physician's time. Here, however, here at the dispensary, were people whose need was just as great, yet who could not afford to pay for such hours of time. Their lives were fallen upon evil days because they could not. The doctor in charge of the medical clinic wanted to help these victims of mental and emotional maladjustment to turn the experience of life into a victory instead of a defeat. He could not give them, individually, the hours upon hours of time, but he conceived the idea that it might be possible to give weekly instruction in mental and moral hygiene to patients in a group, and thus help them to direct the compulsive force of the emotions into constructive affects instead of destructive. The Class in Thought Control had a small beginning, with four patients, in May of the year 1930.

Inner discords are inevitable. All people have them. The business of living involves continual repression. Without repression human personality drives straight for disaster, either moral, mental, or physical. And repression means conflict. But it is just repression—particularly when it is lifted up into sublimation—that enables human nature to make continued evolutionary progress toward higher goals. The primitive outreachings of instinct and desire are brought under the sway of intelligently conceived ideals. What life ought to be as a whole—that is visioned. The part is put into its proper place in relation to the all. The struggler learns to see values from the standpoint of relative importance. He learns to make his choices on the basis of reason and judgment. He learns to reconcile himself to the necessary facts of life. His instinctive nature and his volitional nature are taught to live in harmony. Latent striving is made one with

conscious striving, and that on the high level and not on the low.

Conflict need not issue in disaster. Neither is it necessary for a complex to have that issue. Either of them can be so dealt with that the end shall be a more virile, more masterful, happier, better habit of life than was in the saddle before.

Every self is the result of choices. Not one choice merely, but daily choices, hourly and momentary choices; the same choices oft repeated, and held to through thick and thin. What is called "personality" is not an original entity, but a product, a result of purposes and choices and efforts.

The Class in Thought Control came into being in order that disorganized, struggling souls might be helped to integrate an ordered and successful personality, and thereby find their way into a kind of life that would be fundamentally successful and happy. When Professor McDougall speaks of "purposive striving" as a primary tendency of human nature, he throws light upon many of the morbid symptoms from which people suffer. They are striving, and with purpose; but consciousness and subconsciousness are striving diversely. The self-conscious nature is crying out for a satisfaction which the subconscious endeavor is continually thwarting; or the instinctive nature is striving toward an end that the self-consciousness is hardly aware of, and that it would discountenance if it gave thoughtful and intelligent consideration to its way of life. What is needed in either case is clear-headed and creative use of the conscious mind. For if, as Professor Hocking says, "we are conscious of our 'subconsciousness' all the time," it is also to be remembered that our subconsciousness is conscious of our consciousness all the time. And, as Morton Prince pointed out, the dormant complex is affected by the conscious ideas, and the setting and meaning that are given them.

We are discovering now, more than the past was ever able to discover, that the mind is an exceedingly mysterious and subtle instrument. If, in the case of one man, the subconscious activity of the mind can give birth to the entrancing lines of *Kubla Khan* during sleep, and, in the case of some other man, can suddenly present to the consciousness the solution of a mathematical problem which up to that moment had

been insoluble, then it is not surprising that in the case of still another person the subconscious activity of the mind should give rise to a physical symptom which affords a kind of expression for some torturing and explosive emotion. In the Middle Ages men and women (not all by any means; some went from far different motives) sought, by entering the cloister, to get relief from conditions of life which they could not handle satisfactorily. That is what Freud calls a neurosis: a flight from life, and the modern equivalent of the cloister. Men and women (again not by any means all of the sick, but one here and one there) by developing handicapping physical symptoms find a kind of relief from conditions which are too much for them. Not often is that done consciously, but desire for relief from the facts of immediate experience works subconsciously until the incapacitating symptom is developed.

The Class in Thought Control aims to reach the rebellious and unreasoning subconsciousness, and to make it a constructive force instead of one that is destructive.

Look at a picture of the class in action; then the possibilities of the method become apparent.

Outside it is raining, raining hard. But rain hasn't kept them away. From East Boston and South Boston they have come, from Milton, from Roslindale, from Roxbury and Dorchester, from Belmont, from Revere, from one of the Newtons, and of course from the near-by South End—dispensary patients, and two or three private patients referred from the doctor's Back Bay office. One woman is brought in by a nurse in a wheel chair. Another, who came with a nurse a week ago and drooped so in her seat that she seemed hardly to attend to what was said, comes now alone and holds herself erect as the rest. These two are from the hospital department.

At the left of the speaker's rostrum and facing the rest of the group is the Honor Bench. One of the women sitting there has attended class ninety-three times, and gets so much from the weekly meetings that she cannot bear to miss one. Another has a record of sixty-five sessions, another of fifty-one, another of forty-eight. Seven are on the Honor Bench to-day. These are living examples of the control the mind can exercise over the body. On the front row of chairs, facing

the speaker, are the new patients, eight of them. Toward the back of the room are four who came for the first time a week ago. They will be moved forward, chair by chair, as their attendance record increases in succeeding weeks.

All over the room the buzz of friendly conversation, smiling faces, bits of laughter. This is a weekly reunion to which many look forward with pleasure. The members have an interest in one another as personalities. They are not merely patients seeking a common relief. They have become friends, a good many of them.

The doctor comes in—alert, vigorous, smiling, radiating friendliness and good cheer. He begins the session with the checking up of attendance, and as he attends to that, he speaks a word of greeting to this individual and that, and keeps up a stream of informal talk.

"I know you are surprised that your doctors, after examining you, sent you to this class instead of giving you medicine," he says, addressing the puzzled newcomers. "But the doctors down in the medical clinic couldn't find anything organically wrong with you. They decided that the source of your symptoms is in *you*—that is, in your personality—and not in some part of the human machine such as the heart or stomach, as you thought. Your symptoms, they believe, are simply the outward signs of a subjective trouble. In this class you can learn how to secure equanimity, and how to get a normal personality. We don't attempt here to treat actual organic disease; but shortness of breath, weakness in the small of the back, pain in the left chest, pains in the abdomen, exhaustion, stomach trouble, nausea, palpitation of the heart, faintness, constant fatigue, headaches—these and many other distressing conditions may all be the effects of mental agitation, and can be helped by the principles taught here.

"Don't think I am saying that the symptoms are unreal. Don't say, 'If *you* had this pain, you wouldn't think it imaginary.' Of course the pain is not imaginary. It is real pain. Pain of emotional origin is often more severe than pain due to organic disease. Nervous fatigue is more distressing than the true muscular fatigue that results from hard labor. But if your symptoms have a psychic origin, you can get the mastery of them by your own inner power just as these others

have—these whom you see here—during the past few months. *You can't change the world, so change yourself,* is a true saying and one I often repeat here. Put good mental habits in the place of bad mental habits. The only possible way to get well is to change yourself. When you——Well, I'm glad to see *you* again, Mrs. Cantry! It's a long while since you were here last. How are you getting along?"

"I'm still fighting. I don't really feel capable of speaking. I guess I don't come often enough."

"If you watch any part of the body with apprehension, it will give you trouble," says the doctor. "A real hero goes ahead in spite of fears. It's like that story about one of Napoleon's marshals who found his knees rattling against his saddle just as a battle was beginning. 'You poor knees,' he said, 'how you would quake if you knew where I am going to take you in a minute!' Mrs. Nussbaum, how are you getting along?"

"My state of mind is much better. I did it by just stopping to worry about things. The thoughts"—she shrugs her shoulders and lifts her hands—"I would drive them out of my mind. I remembered the class, and what you said."

"Mrs. Nussbaum," says the doctor, "though not physically better, gained courage and ceased to be a slave to her symptoms. Turn on your enemy. Say to your pain: *'Ache all night if you want to!'* Many, when suffering from pain, have helped themselves by saying, *'Go ahead and hurt!'* I was reading an old book last evening, and came upon Seneca's fine words about some Romans who were trapped in an ambush. 'The three hundred Fabiæ were not defeated; they were only killed.' That's fine! Always give yourself helpful suggestions. All of us have in ourselves great reservoirs of unused power. Be encouraging with yourself rather than critical. But remember—your release from symptoms depends upon your learning to adjust yourself to the facts of life as they are! That is, you must accept an environment if it can't be changed, and make the best of it. When you do that, you find that your condition improves at once."

There may perhaps be a little more talk—comment and instruction. It is all very informal. But after the roll-taking

there is a pause. The relaxation period is an important part of the class procedure.

"We get peace of mind and a sense of increased power by learning to relax physically and mentally," says the doctor. "Relaxation of body and mind gives both rest and refreshment."

He pushes notebooks and papers aside, and asks all who are present to rid their fingers and laps of handkerchiefs and bags and other encumbrances.

"Take a comfortable position on your chair," he says, "as if you were preparing to go to sleep. Put your feet side by side on the floor. Let the floor hold them up; don't try to push the floor into the cellar. Let your eyelids drop. Don't snap them together; let them fall gently, and then keep the eyes closed throughout this period. Now your head—let it fall forward. Loosen all the muscles of your neck. Unbend the muscles of your mouth. Relax the muscles of your jaw. You'll find that the lower jaw will sag a little. Now smooth out the wrinkles of your face—the lines of your forehead. Let your hands rest in your lap. Don't hold them up by your arms; let your lap hold them. Now let every finger be loose, as loose as a dish cloth, every finger."

Item by item every part of the body is called into a state of relaxation as the directions are given quietly and slowly. The room is hushed. Even the noise of the near-by crowded thoroughfare is not noticed. All are breathing gently and calmly. One or two even lapse into momentary sleep.[1]

"While you sit here relaxed," says the doctor, "with your eyes still closed, we're going to make a picture. It is to be symbolic of peace of mind. Fix your attention fully on the picture and the surface of your conscious mind will seem smooth as a mirror, unruffled by a single disturbing thought throughout this exercise. Try to see the picture with your inward eye, your imagination, as I paint it in words. A lake in the wilderness, miles from any human habitation—somewhere in Maine. Not a large lake, but one perhaps a mile long

[1] Credit for this simple method of relaxation belongs to Dr. Elwood Worcester. See *Body, Mind, and Spirit*, by Elwood Worcester and Samuel McComb (Boston: Marshall Jones Company, 1931), p. 194. See also Worcester's *Making Life Better; An Application of Religion and Psychology to Human Problems* (New York: Charles Scribner's Sons, 1933), p. 159.

and half a mile wide. You are sitting relaxed on the warm ground, beside this lake in the wilderness—forest stretching back in every direction—warm, summer air—about half-past two in the afternoon. Not a breath stirring; not a leaf moving; not a ripple on the lake. Note the motionless surface of the water. It is as smooth as glass. Look quietly at that picture. Do it for thirty seconds."

After this, while the eyes are still closed, hands are counted to find how many have really relaxed and how many feel mentally serene. Eyes finally opened again and shoulders straightened, perhaps some member of the class will volunteer a word about practicing the relaxation at home and making the mental picture, even though she has never been out of the city, and being helped thereby to go on with the day's strain and stress.

Then comes the third part of the class procedure, if the day conforms to typical routine.

The doctor turns to the first-timers.

"I want you to see," he says, "what some of these older members have gained from the class. They came here to-day not because they need help, but to help you. Mrs. Shallahan, tell us about your experience."

A hearty, wholesome, enthusiastic woman of somewhat less than middle age speaks from the Honor Bench.

"For three long years I was sick with arthritis, and couldn't move an arm or foot. They carried me into the hospital on a stretcher, and out again on a stretcher. I was there six weeks, but they didn't do much for me but give me medicine, and I figured I could do as well at home and be much more contented with the children about me. When I got home, I could walk only a little, and I couldn't use my hands at all. I had to wait for somebody to feed me, dress me, and put me to bed. To get downstairs I had to sit and slide along. I had to use a hammer to open the faucet, and couldn't lift a kettle except by holding it on my arm. I was told that rheumatism might go to the heart, and so when I began to have trouble in my stomach, I feared it would do that because my heart was only a few inches away from the spot where I had pain. I thought I was going to die.

"Finally I came to the dispensary. I was examined, and

the doctors couldn't find anything to lay a finger on. Doctor N. told me I had no arthritis, and that all my symptoms were due to nervousness. I stopped taking medicine, and threw it down the sink. Doctor N. sent me to the class. He said I could get well here.

"The class put me on my feet and made a new woman of me. I expected sympathy, but I didn't get any. I got something better, and that was courage. That is what has put me where I am to-day—courage. Without courage you can't do a single thing. I cried three long years, and I cried alone; from now on I'm going to smile all the while. You can't think of your troubles while you're smiling."

One of the newer members speaks up: "What did you *do*? Rest, diet, outdoors—or what?"

"Eating hasn't nothing to do with it. You do it from the inside. I have troubles still. My husband's out of work, and I have five boys to care for. But I know how to take care of my troubles better. My recovery has changed the house altogether. I don't know myself, and nobody else does. When I first came to the class, I thought they were all crazy. I didn't get anything out of it, and couldn't see what good there was in sitting here and listening to a lot of talk. But now I think it's the most wonderful thing in the world, this class. Thank God and the class, to-day I haven't got a single pain!"

Here may be included, parenthetically, what the dispensary medical record says of this case: "Complete relief from all symptoms by psychotherapy."

The group is very evidently impressed and moved by Mrs. Shallahan's story.

"You can feel emotion," the doctor warns, "but unless you translate that emotion into action, it won't do you any good. The mind has both voluntary and involuntary control over the body. Trouble is usually attributed to environment; but changing the environment rarely meets the difficulty, because the real trouble is in yourself. You must create new habits for old, good habits for bad. We can't prevent anxious thoughts from coming into our minds, but we can prevent them from staying there. Mrs. Raice, tell these new members what Thought Control has done for you."

Mrs. Raice is eager to talk. She lives for the weekly sessions of the class, it is said.

"I had seven years of sickness," she begins. "I couldn't sleep. I had a hot temper. I was a miserable person to live with. If I saw any dirt in the house, I just went crazy. If I didn't have the table all set and supper ready when my husband came home at night, I would yell and screech and have an argument with him. Just the fact that he was there waiting got me panicky. For years I thought I had a mutt of a husband. When he came home after a single drink, and was perhaps fighting the craving, I would get excited, and use harsh words, and drive him to a spree instead of helping him in his fight. Now I say nothing, and keep calm. That helps him, and he and I get along swell. I've got a wonderful husband as husbands go. I was living my whole life antagonistically. I exaggerated little troubles. I was at the point of suicide. I thought I had heart trouble—a leaking valve. A doctor once told me so. I know now that my heart is perfect, and it was just my nerves that made me feel that way. I want to be perfect myself, and to have every one around me perfect, and that kept me all stirred up. Now I let other people live their life, and I live mine.

"When I came to the class, I saw the point at the first meeting, but I had to go home and thrash it out by myself. 'If these other people can do it,' I thought, 'why can't I? I'm no different.' I began to realize it wasn't the world that was wrong, but me. Now I'm a new person altogether. I'm healthier than ever before in my life, and happier. In the old days I didn't ever relax, even in my sleep. Now I don't bustle around as I used to, and I get the same amount of work done, and don't get tired out as I used to. We've moved to new quarters where I live closer to the neighbors, and I get along fine with them. The class is just great. If I have to miss it for a week, I feel the need of it. I can't get along without it. I used to have thirty-nine dollars a week and worried; now I have eleven dollars a week and don't worry. Worry isn't dragging down my life now, and my husband and children have changed since I began coming here."

"And you practice the class ideas at home?" asks the doctor.

"I can still have aches and pains any time I want them, but I just force myself to forget pain if I have it. I understand myself now, and am able to control my symptoms. I cured my

boy, too. He's fifteen, and he came home with hysterical paralysis (that's what one of the doctors told me it was), and I cured him by using the class principles. My attitude toward everything is changed. The class is just like new life to me. Before I came here I didn't want to live any more, but here I get courage for every week."

It has seemed best, instead of putting these stories into another form, to let the patients tell them in their own words. The discerning reader, peering between the lines, can learn much about the kind of need the Class in Thought Control is meeting, and what the intelligent application of its principles is doing for those who attend its sessions.

The critical visitor wonders sometimes if the high lights are possibly made a bit too high, and the low tones a bit too low. A natural desire to impress the newcomers, and also a natural desire to please the leader, no doubt affect what is said. The passing of time and frequent repetition must also have an effect upon the story. Moreover, the listener is treated to the patient's idea of what *she thinks* was her malady at the beginning, instead of to the authentic medical diagnosis. But to cure the suffering of what *they think* they have is one chief purpose of the class. And if there really is some fundamental physical disorder, it is none the less important that the victim should develop an enthusiasm for making the spirit victorious over the assaults of the body, and learn the art of so doing. The purpose of the Class in Thought Control is not merely to remove symptoms. It is, to quote Paul Dubois of thirty years ago, "to make the patient *master of himself.*" In other words, the correction of emotional prehension is a primary element in the class purpose. The victim of life must learn to accept life. He must learn to love life. Not the conditions and circumstances of the moment, but life as a transcendent experience with immeasurable possibilities for the soul which is in the making.

Even if in certain cases some discount needs to be made from the stories as told in class, there is value in the testimonies. The hearer knows that *something* has taken place, or is taking place, which is making life a different matter for that individual. And the teller is confirmed and strengthened in his new attitude toward himself and toward the world, while

at the same time the Aristotelian principle of catharsis is at work within him. By giving vocal expression to his morbific emotions of fear and rebellion and self-pity (giving them expression under proper conditions and with "creative listeners" at hand) he begins to be "purged of such emotions."

A typical class session lasts an hour and a half. There are days when two or three testimonies of the kind just quoted will take up all the free time. On other days the time will be used for a number of brief testimonies, or for a detailed explanation by the doctor in charge or by one of his associates, with blackboard diagrams, of the psychological causes of the neuroses from which those who have been sent to the class are suffering. The chief appeal is to the emotions, rather than to the reasoning powers, of the hearers.

There is distinct advantage in having the class meet at the dispensary, with its large staff of doctors, nurses, and social workers, and its many departments, including hospital rooms. A large number of the patients, perhaps all, still keep in touch with the clinic. When physical treatment is needed, it is recommended and given. But the doctors of the clinic are expected, in addition to whatever they attempt physically, to supplement the class influence by using individual psychotherapy in so far as they are able to do so.

A significant side light upon the value of the class was given by Mrs. Raice, whose experience was cited above.

"I came back," she said, "for a place to go to."

In the class she finds food for her hungry mind and stimulus for her spirit—things not easy to find in a tenement home and environment. She finds also a social contact that her aspiring soul craves—contact with at least some who are above her in the social scale, and whose education and thoughts and interests are different from those of her ordinary companions. Her life is broadened by the weekly hour in class. Moreover, she finds herself there a person of some importance. Her words are listened to. She hears others, who also have been in the depths of struggle, tell of the definite impetus they received from her words. Thus the group method reaches ends that a personal and private psychiatric session could not reach.

Impoverishment of mind and soul is the direst poverty after

all. Saint Francis could choose Lady Poverty for his bride, but the satisfactions of his heart and spirit who can measure? Epictetus could live without a wife and without a country, and have as property only a pipkin, an earthen lamp, and a bed, and be happy, find life an enriching experience; but his inner life in mind and soul was heaven on earth. For people in general it is neither necessary nor desirable that life should be lived materially as these lived it; but it is of the very essence of true life, for all sorts and conditions of men, that mind and spirit be given all the enlargement and enrichment of which they are capable.

The essential work of the Class in Thought Control is to help inharmonious and struggling souls to build up a new world of desire and imagination and thought and to make therein their permanent abode. Every person, wrote William James in his *Varieties of Religious Experience,* has open to him "two spheres of thought, a shallower and a profounder sphere, in either of which he may learn to live more habitually." The patient who learns to look upon his neurosis as "the negation of life"—to adopt the admirable phrase of Poul Bjerre, of Stockholm—and who, therefore, turns himself about and sets his face toward the *affirmation* of life, with the object of drawing into himself life more abundant and more true—that patient has begun already to master his impediments. He is already on the way to freedom from mechanistic morbific reactions, and to at least some progress toward being master in his own house of life.

THE TREATMENT OF READING DISABILITY

NINA RIDENOUR

Psychologist, The Children's Center of the Children's Fund of Michigan, Detroit

DURING the last few years, while the diagnosis of reading disability has been stressed in the literature,[1] the remedial aspects have been neglected. Teachers, psychologists, social workers, and others in a position to help the child feel bewildered when confronted with the problem of severe reading disability.[2] This paper attempts to bring together suggestions for retraining of the type already described by Monroe [3] and Orton,[4] and other methods worked out by the writer in the tutoring of children of normal intelligence who were from two to five years retarded in reading.

The first consideration, before any move is made toward actual tutoring, must be the child's attitude. Does he *want* to learn to read? If he does not, then the problem becomes, not teaching him to read, but understanding his resistance to reading, and getting him to want to read. This may mean hours, weeks, of case-work. Clinical experience shows that not only is it a waste of the time and effort of all concerned to try to teach an indifferent youngster, but it is worse than

[1] See "Interference in Reading," by Joseph Jastak. *Psychological Bulletin*, Vol. 31, pp. 244–72, April, 1934. This is an excellent summary of the literature. The bibliography contains 171 titles.

[2] See "Retraining in Reading—A New Method," by Jeanette Regensburg. *American Journal of Orthopsychiatry*, Vol. 1, pp. 163–72, January, 1931. This article offers a list of symptoms with which every teacher should be familiar, "not as a basis for diagnosis, but as suspicious indication" of reading disability.

[3] See *Children Who Cannot Read*, by Marion Monroe. Chicago: University of Chicago Press, 1932. See especially Chapter V (*Causative Factors in Reading Defects*) and Chapter VI (*Remedial Instruction; Methods*). The book contains instructions for administering the Monroe Diagnostic Reading Examination.

[4] See "Specific Reading Disability; Strephosymbolia," by S. T. Orton, M.D. (*Journal of the American Medical Association*, Vol. 90, pp. 1095–99, April 7, 1928), and "Special Disability in Spelling," also by Orton (*Bulletin of the Neurological Institute of New York*, Vol. 1, pp. 159–92, June, 1931). Orton offers an interesting theory as to the causes of reading disability.

a waste, because it adds one more failure to his list. Pressure that the child is unable to accept is destructive and builds faulty attitudes of which he will bear the scars throughout his life. Occasionally it may be necessary to build in the desire to read by indirect methods, getting the child to want to grow up, to want to face his problem, and so forth. More often, he is relieved at having his difficulty at last understood and eager for help.

Granted a favorable attitude, there is still some art in explaining the situation in such a way that he will understand it accurately and will realize what is going to be expected of him in the way of attention and hard work. If this is done, roundabout and time-consuming methods of rousing interest by pictures and games can be dispensed with, because the child's interest and effort are from within. It has become *his* problem, *his* challenge. It should be put to the child as an unfortunate occurrence that he has this difficulty, but that while it is his bad luck that he has it at all, it is his good luck that it has been discovered and can be cleared up, so that he will not get the reputation of being "different" from other children. With the proper attitude on the part of the child, the tutor's energies are free to be directed to methodological rather than psychological problems, and progress is increased many fold.

Any person who has good rapport with the child should not fear to undertake tutoring, regardless of whether or not she has had experience in teaching. Common sense and ingenuity are more important than experience in classroom teaching, for the reason that the methods called for in tutoring are usually very different from the methods commonly used in the classroom. Because the regular methods have failed with this child, the tutor is justified in attempting different methods. As a rule it is actually the so-called "old-fashioned" methods that these children respond to most readily. Perhaps the teaching of letters and syllables is disapproved in the child's school, which may pride itself on teaching phrases and large units. But usually learning word by word seems to be the only way this type of child can learn to read at all. As Orton says, "It is better to be a word-reader than a non-reader." Let the tutor keep her ideas flexible enough to be willing to follow any method that

works. The child has failed, other methods have failed; the tutor is now seeking the individual methods that will aid this individual child. There is *no* rule-of-thumb approach.

It should be planned to have just as many lessons a week as can possibly be arranged. The more frequent the lessons, the better, especially at first. This is sometimes difficult in a clinical set-up. The needs of the particular child should determine the number of lessons per week. There is no question but that in some cases seeing the child only once a week, or perhaps even twice, is worse than not attempting to see him at all, for the reason mentioned several times in this paper—he is the more discouraged because he has failed once again. In many cases it is absolutely essential that the tutoring be intensive. The results will repay this effort.

The writer, both in her own tutoring experience and in supervising inexperienced tutors, has found Monroe [1] by far the most helpful of any of the writers on the subject. The chapter on remedial instruction in her *Children Who Cannot Read* is full of sound and helpful suggestions, and she presents logical steps for procedure which are invaluable to any tutor. These steps begin with series of words of three sounds, including one short vowel, such as "man," "cat," "can," "rat," "had," "bed," "beg," "let," "hen," "get," etc., one list for each of the five vowels, a, e, i, o, and u. Step II consists of the differentiation of short vowels—"hit," "hat," "hot," "hut," "bat," "bit," "bet," "but"; etc. Step III takes up four sounds, including one short vowel or three sounds with double consonants. Then follow words with five sounds, words with two syllables, long vowels, vowels formed by two or more letters, on up to vowel and consonant variants and complex syllables.

Familiarity with the two chapters in Monroe already cited [2] will help the tutor to clarify the problem in her own mind and to plan the best methods. Longer lists of words of the type suggested by Monroe should be prepared. The tutor will need to acquire—this can be done in an hour's practice—facility in printing in lower-case type. Her letters may be simple in form, but it is essential that they be accurate. If she falls into such habits as turning the tail of "g" back-

[1] *Op. cit.*

[2] See note 3, page 387.

wards, or lengthening the stem of "a" so that it is confused with "d," the value of printing over longhand will be lost. It has been found that

printing something like this

from one-fourth to one-half inch high, is easily grasped by the child.

There are any number of forms according to which the material can be planned. One convenient way is to use three-by-five cards and slips of paper about the same size. These can be filed in a regular file box for easy reference and for carrying about. One set of cards should consist of the alphabet, one letter on each card. If Monroe's suggestions are being followed, the next set will be a series of three-letter, short-vowel words. Lists of about fifteen words are a good length for most children, for this makes the list long enough not to be easily memorized, but not long enough to be discouraging.

The tutor, in starting the lessons, should take nothing for granted. It is surprising how many children reach the fourth or the fifth grade without knowing the alphabet. If the child does not know the letters, it is often advisable to spend some time at each lesson on letters. As with each of the steps that follow, it is not necessary for the child to achieve complete mastery of any step before he goes on to the next, but he should be well grounded in each step, and consider complete mastery as the final goal.

With any except a very young child, it is possible at this stage to explain the difference between vowels and consonants. The five vowels—a, e, i, o, and u—may be separated from the other letters of the alphabet, and some time spent in teaching the short sounds. If the child has difficulty with these—as he will—he may select a key word to help him remember each, and write it on the back of the card. For instance, to help him remember short "a," he may choose "cat," "at," or "man"; for short "e," "set" or "let"; for "i," "it," "him," or "sit"; for "o," "hot" or "stop"; for "u," "cut," "cup," "fun." Any two- or three-letter words with a short-vowel sound will serve. As he works on the lists of three-letter, short-vowel words, he may be helped

by having these five cards spread out before him. When he is having trouble with a word, he can refer to the card that has the same letter; if that does not recall the sound, he can turn it over to the familiar key word. This will teach him to build associations consciously, and to use associative aids when he is having difficulty.

If the child has a severe disability, it may be necessary to spend a good deal of time teaching him to sound out words. Some children get the idea of sounding out letter by letter, but have great difficulty in sliding letters together. The writer tutored one boy of twelve years whose intelligence quotient was 124, while his reading was at a 1B level, although he had been in school for six years. He was absolutely unable to learn words as words. The only way he could learn was by being drilled lesson after lesson, first on the initial sound of the word, then on the second sound, then on the combination; next on the final sound, then on the combination of these, and finally on the word as a whole. This really represented six separate steps. For instance, to recognize the word "met," he had to learn first the initial "m" sound, then the short "e." Next he put these together to make "me." The "t" was then added, but that made "me-t," and another trial or two was necessary before it could be blended into the recognizable word "met." Long after he was able to sound out letters and syllables correctly, he had the greatest difficulty in blending them into words. This difficulty is characteristic of many children who have been unable to learn to read by the regular school methods, and it seems to be connected with weakness in auditory discrimination as well as with inability to grasp large visual units such as words or phrases. By drill and persistence, they can be taught to blend sounds into syllables, and syllables into words, when they have been unable to learn in any other way. This is a long, slow process, it is true, but, again, it is better to be a word-reader than a non-reader.

With children who need this kind of tutoring, not only should there be no pressure for speed, but the child should be exhorted to take his time, to "sound it out." This is a phrase that the tutor repeats hundreds of times—"Sound it out." If it is observed that the child is beginning to read words more rapidly, that fact can be mentioned as an indi-

cation of improvement, but increased speed should not be held up as a goal.

Another phrase that the tutor repeats constantly is, "Follow with your finger." This often meets with considerable resistance from children who have been taught that it is "babyish." Schools are often severe on this point, holding that following with the finger makes slow readers or word-readers. Actually it is only the slow readers who need this aid, and instead of making the child slower, it is helping him. It has been shown that slow readers have more regressive eye movements than good readers. Learning to follow with the finger may be of inestimable assistance to them; sometimes it is the greatest single aid in point of method that can be given.

Practically all children with reading difficulty have more trouble with the letters "b," "d," "p," and "q," than with other consonants, and continue to confuse these long after other letters are clear. Rarely is the child aware of this confusion. Most of them need frequent intensive drill at first, and continued occasional drill on these letters separately and in words. The child is interested in discovering that "b" and "d" are just alike, except that they face in opposite directions, as are "p" and "q." The tutor should be constantly on the look-out for individual confusions such as between "m" and "n"; "u" and "n"; "f" and "t"; "e" and "t"; "a" and "s"; "a" and "r." Any of these, when encountered, show the need for drill and review.

It is possible to introduce considerable variety into the lessons, even though no books are being used at this stage. One of the advantages in having a single word on each card or slip is that the child himself can handle these. He can sort them according to initial letters, according to vowel sounds, according to difficulty, and so on. He can copy them in writing or write from dictation. If a blackboard is available, he can write on this, or read as the tutor writes, or trace over the tutor's writing. This method of sounding a letter or a word and tracing it at the same time is helpful to some children, but laborious and artificial to others. There are many kinds of oral drill that are helpful to children. If his diagnostic examination has shown weakness in auditory discrimination, the child may need practice in identifying

sounds and in blending syllables. If he has difficulty in orientation, he can practice identifying initial sounds and syllables or letters. The child who reverses excessively is likely to say that "desk" begins with a "k" sound, or that "ask" begins with "s." He needs different kinds of drill in establishing orientation.

In teaching the sounds of letters, it is important that the child give the pure sound accurately, not adding an extra "uh" sound. If he learns "s" as "suh," "m" as "muh," he may be unable to blend "suh-end" into "send" or "muh-ore" into "more." It is better to place most stress on the initial sounds; the final ones will often take care of themselves. Moreover, if attention is consistently directed to the first part of the word, there is less danger of additional regressive eye movements. If the child is taught the "families" —"send," "lend," "bend," "tend," and so forth—he may learn to look first at the end of the word, and then to let his eye move back in the wrong direction. Inasmuch as keeping the eye moving in the right direction is a main source of difficulty with many children, every effort should be made to build the habit of eye movements from left to right. Anything that can be taught by "families" can be taught by the use of words that begin alike: "sap," "Sam," "sat," "sad," "saddle," "sank," "satisfy"; "bet," "bed," "bell," "best," "better," "bend"; "pin," "pit," "pity," "pinch," "pink," "pick," "pickle," and so on.

There is advantage in combining repetitive drill that does not vary from lesson to lesson with variety and something slightly new in each lesson. The child is kept stimulated by the new, but he derives satisfaction and security from the familiar. What is more important, he sees his progress from day to day, his increased speed and greater accuracy, and he can measure these better because he is succeeding with the same material that was difficult or impossible for him at first.

If the child is in the fourth or fifth grade and his reading is retarded, say, only a year or two, he may look upon these three-letter, short-vowel words as "baby stuff." Even so it is well for him to have some drill in them; it may be this very sort of thing that he needs to build a proper phonic base. He may be able to read the words, but unable to apply the principles in tackling new words. He may dash through the list.

making many errors attributed to "carelessness," whereas it is the tendency to these very errors that is responsible for his retardation. Analysis of errors due to so-called "carelessness" reveals that most of them are due to confusions, misconceptions, faulty habits, or some other definite cause, instead of being due only to haste or indifference, as the word "careless" implies. A major task of the tutor's is to locate quickly and surely the causes of the child's own errors and to work at them intensively.

To this end the tutor will want to keep detailed notes on each lesson. Often some particular difficulty will become clear only in the light of previous difficulties, or only when notes from earlier lessons are compared. This is only one of the many purposes served by notes. Another is that the notes can be used for review. If the tutor prints each word missed during the lesson, these are invaluable for later drill and review, and center all attention on the child's own errors. The child is able to see his progress by realizing that he now reads easily what he could not read at all before. The tutor can make any notations that seem pertinent: "List II without error, first time"; "Four confusions of 'b' and 'd' "; "Finds short 'o' easiest of any vowels, confuses 'e' and 'i' "; "List IV, new, only five errors; list II, review, 47 seconds, O.K."; "Seemed tired to-day, eager for lesson to end"; "First signs of reading words as words, without sounding out"; "Insists on spelling hard words, but able to read them correctly second trial"; "Remembered to follow with finger without being reminded for first time"; "Says, 'P and q have gone wrong with me again'." In this way the tutor can look back on the whole series of lessons and see the plateaux, the regressions, the more and the less helpful techniques, the changing attituds, and other details of progress.

For the child who is seriously retarded and who has a long period of failure back of him, reading in a book is to be avoided entirely at first, and then approached cautiously with careful preparation. He may need to be introduced to reading through phonetic sentences, composed by the tutor:

"Don had bad luck."
"The sled hit a big bump."
"They sent help to the ship."
"We wish to do a trick."

The child can read sentences like these when even the simplest book is still beyond him, if he has been taught by the methods suggested here. As soon as he is able to do this kind of reading, it is time to introduce the more common nonphonetic words, such as "to," "who," "toward," "were," and others that are phonetic, but that he has not yet been taught, such as "how," "these," "why," and so forth. The child sometimes enjoys beginning to master confusing lists, such as the "wh" and "th" words: "who," "which," "what," "where"; "this," "that," "these," "those," "there," and so forth. At this point it may be helpful to give him a card with two or three words on it which are to be learned by the next lesson. Avoid giving him more than a few words at a time.

If the child has mastered even reasonably well the three-letter, short-vowel words, he will have no trouble in advancing to short-vowel words with double consonants. Long after he has started to work on these, it will be well for him to continue to review the original three-letter words, especially those involving vowel differentiation.

The teaching of some phonograms, especially double consonants and prefixes, can be started at any stage. Learning new words is speeded up if the child recognizes promptly such combinations as "gr," "sl," "bl," "sn," "qu," "br," "pr," "spl," "scr," and so forth, and "pro," "un," "re," "or," and so forth. Some children experience difficulty in proportion to the length of words, and are troubled by words of two syllables even though they are simple phonetic words. These are usually the children with a tendency to excessive reversals and other forms of inadequate orientation.

Children have relatively little trouble with long vowels if they have mastered the short ones. It is sometimes helpful to use the old familiar reminder: "An 'e' on the end of a word makes the vowel say its own name."

From this point on, the lessons should be directed almost entirely according to the child's own needs and difficulties. As more reading in books is done, the tutor should begin to keep a permanent record of words confused by the child. The following are samples of the confusions of one child, taken from notes covering a period of four months: "quite," "quiet," "quit," "queer"; "slapped," "shaped," "shaved,"

"shoved"; "hand," "hard," "head," "heard"; "tried," "tired," "tied"; "shortly," "sorting," "shouting"; "would," "wont," "want," 'world," "wrote"; "bury," "burn," "born," "barn," "bun"; "changing," "clanging"; "knew," "went"; "thorn," "throne"; "maker," "marker"; "huge," "hung"; "moose," "mouse." These serve as excellent review work, and also clarify the particular confusions of the child.

There is one point that cannot be overstressed: *select reading that is easy for the child.* The greatest incentive that the child can have is his own success. These children are practically all discouraged with reading. The average child gets more deep satisfaction from the realization that he is actually reading a book than from all the pæans of approval the tutor can heap upon him. There is no need to be concerned about selecting a book that is too simple: it is practically impossible to get one too simple, especially in the case of the first few books. It is sometimes difficult to find books that are easy enough in reading matter, and yet not too babyish in content for the older children. The following are a few that the writer has found helpful:

Angus Lost, by Marjorie Flack.
Little Toy Airplane, by Inez Hogan.
Penny Whistle, by Erick Beery.
Humbo the Hippo, by Erick Beery.
Millions of Cats, by Wanda Gag.
Big Fellow, by Dorothy W. Baruch.
Round the World in a Mailbag, by William Siegel.
Ola, by d'Aulaire.

The writer has had the experience of seeing the whole attitude of a child change in the course of a few minutes when the book presented was too difficult. Throughout the lessons up to that point, this particular boy had been eager, conscientious, never wasted time, worked longer than he was expected to at each lesson, and was making rapid strides. When, after seven or eight of the easy books, he was given a book in line with his age, but still somewhat above his reading level, within a few minutes he became restless and indifferent, pleaded fatigue, was inattentive, and wanted to stop early. This lack of effort and interest had been described by his teachers, but no trace of it had been shown to the tutor. The difficult material recreated his discouragement with school,

and, had it been forced on him, would have meant the end of progress, and, what is more, another failure. As it was, with a return to the easier reading, his effort was renewed, with the result that he was soon able to read what had been too difficult for him only a short time before.

The tutor will need to decide when to urge some particular method because she is convinced that it is a good one, and when to discard it because it is unsuited to the individual child. For instance, she may meet resistance in trying to teach the child to follow the reading with his finger, and yet may feel justified in urging this, or she may decide to discard that method for this particular child although it has worked well with others. She will strive to make drill as attractive to the child as variety, and will enlist the child's interest in her notes. Above all she will keep her methods flexible, and her attention alert. Under these conditions it is not unusual to see a child's reading show a gain of from two to three years in a three-month period, or in from twenty-five to thirty lessons.

MENTAL HYGIENE AS APPLIED TO INDUSTRIAL-ACCIDENT PREVENTION

EDWARD R. GRANNISS

The Travelers Insurance Company, Hartford, Connecticut

OUR present methods of accident prevention are based on the presumed need of awakening employees to a sense of responsibility for their own safety. To do this, we spend considerable time trying to scare them into looking out for themselves. Posters showing the horrible results of accidents are prominently displayed. Speeches are made in which the suffering at home as a result of loss of income is vividly explained, and articles are written telling large groups of workers to "do this" or "do that" to avoid dreadful consequences. A number of the individuals for whom this propaganda is prepared pay complaisant attention—and then apply the lesson to some one else. Our general educational campaigns are, no doubt, leaving many things undone.

According to the best authorities, at least 85 or 90 per cent of all accidents have as their proximate causes the mental conditions of workers. This estimate relegates the remainder of the accidents to machine or material failures, "acts of God," and various more or less indefinite causes. The mental conditions that result in error are lack of knowledge, inattention, confusion, and often an unwarranted sense of superiority typified by the "it-cannot-happen-to-me" attitude. These terms, of course, overlap and are dependent for their existence on a number of things, such as experience, training, worry, fear, fatigue, exhilaration, or some mental subnormality, all of which tend to expose the individual worker to hazard.

Accident investigation and analysis usually stop at the first cause, in as much as most plants are not equipped for further analysis and their executives believe it impracticable to go into psychological causes further than to note that the man was inattentive, disobedient, or, perhaps, careless. Records

of this kind are of value in safety work, but do not by any means constitute a full analysis of an accident.

Industrial accidents are not distributed among workers according to the laws of chance. In plants in which records have been kept for a considerable period it has become evident that the workers who have the most accidents (accident prones) will, generally speaking, be found to be the ones who make the most errors in their work, who have the poorer attendance records, and who react more slowly—or more unwillingly—to supervision. Thus, while complete accident records probably offer the easiest method of identifying employees who are misfits in some department of their work, by correcting the mental attitudes of accident-prone employees far more is gained for the plant than a reduction in its accident record.

What should an industrial mental-hygiene program be? Or, rather, what can it be? An ideal can be set up; if it cannot be attained, does it necessarily follow that nothing can be done? First, it must be realized that industrial psychology is not a form of hypnotic suggestion by which employees can be kept happy while receiving abnormally low wages, or made resistant to fatigue through long hours of monotonous labor. As a medium for assisting in the correction of improper attitudes on the part of individual workers, or of increasing the comfort and, incidentally, bettering the morale of a group of employees, there are, generally speaking, three courses open to the average plant.

First, there may be a department of mental hygiene under the direction of a psychiatrist. Such a department will perform the most fundamental work. A psychiatrist, with his specific knowledge of human motivation, appreciates the significance of various attitudes, and can discover and treat mind conflicts, repressed desires, feelings of inferiority, and various forms of neurotic incapacity. He can judge the amount of incentive, industry, and ambition in a new employee, and can obviate, to a large degree, vocational misplacements.

Second, an industrial psychologist may be added to the health-department staff. This should be a person with some medical-school background who has specialized in mental hygiene and has had clinical experience with mental cases—one who can recognize the tastes, capacities, and requirements

of workers, together with their susceptibility for training. A psychologist can determine speed of mental operations, accuracy of performance, quickness of perception, manual dexterity, and ability to remember.

Third, if professional psychiatric or psychological service —which, of course, is the ideal—cannot be procured for a plant, certainly some good can come from a consideration of the mental causes of accidents by proper persons even though they may not be professionals. A department of vocational guidance may be set up. The procedure followed may be similar to the work of reorientation in many of our colleges and universities, in which one of the older professors, with a liking for young people and an ability to win their confidence, spends much of his time, while away from his classroom, in personal interviews with students with troubled minds. Perhaps the new student has not reacted properly to his wholly different social environment; perhaps he is unable to reconcile his past religious outlook with his new studies in science; or perhaps he has chosen a group of studies that are wholly foreign to his interests and in the pursuit of which he will never be content. The advisory professor, through years of watching young people come to college and leave—either as successful graduates or as scholastic failures—has acquired a knowledge of the causes of such success or failure, and so is qualified, by disposition and experience, to offer suggestions as to different and more suitable courses of study. Many a youthful student can attribute his success at school or college to such a confidential talk.

In many factories there are men of high intelligence who for years have watched employees come and go and who have been observant enough to realize why many men were discharged as failures. There is no doubt that a man of this type, through the medium of personal interviews with employees who have high accident records, or who seem to be misfits or problem cases for other reasons, could, with the help of the plant physician, straighten out many confused mentalities and help to instill healthy attitudes. In salvaging a worker who would otherwise be lost to an industry, a service is performed not only to society, but also to the plant that has taken such initiative. Any worker who has gone through the process of being hired and trained for a job represents a very

definite investment for the firm, which investment should be protected. Replacement does not always mean a better man. High labor turnover is a needless expense.

A department of vocational advice needs the coöperation of the employment office. Far more information can be gained at the time of the applicant's physical examination than is usually demanded. For instance, something can be learned concerning home conditions. The man's standard of living; his medical history; his manual dexterity and alertness; his tastes, desires, and ambitions; his disposition and training; his attitude toward certain principles of management with which he will be confronted—such as open shop, biweekly pay days, and no smoking—all can be used to good advantage in placing the applicant or in assisting him later should he get into mental difficulty.

We rarely analyze a man's attitude in connection with an accident. If it is found that he was disobedient or inattentive, he is told to mend his ways, and the matter is usually forgotten, even though the employee suffers further accidents from mental causes. The only action taken by some plants is to protect themselves by dismissing the man in question—if his accidents result in spoiled work.

Attitudes can be changed or molded. This was shown in our own country during the World War, when, through the use of patriotic propaganda, a peace-loving nation was in a short time changed into a very warlike people. Political parties are constantly molding public attitudes.

The attitude of the individual worker can also be changed, but this is usually a personal problem. Men often become obsessed with some idea that dominates all their actions. The idea may be born of a trifling incident that probably had little or no significance, but that, as a result of allowing the mind to dwell upon it, has become a matter of importance. Because a foreman was a bit gruff one morning, the press hand has come to believe that the whole company wishes him ill, and he develops a morbid disposition, disregards rules, and finally is injured or discharged. Another man—a bench hand—while returning home one evening, hears a fanatic speaking from a soap box. Some of the ideas expressed please him and he is now refusing to obey any of the laws of capitalists (personified to him by his employer) and is marking time until

the hoped-for millenium, when the goods of the world will be equally divided. Such attitudes can often be corrected by a confidential conversation. In many a case, in fact, when a man can be induced to express his grievance, merely putting it into words causes him to realize its lack of importance, and he returns to his job feeling better than he has for weeks. Many accidents occur to men while they are in a depressed frame of mind.

An employee may lose interest in his job after he has thoroughly mastered it. Even though a man may for a time enjoy the work to which he was assigned on employment, his interests may change as he gains knowledge and experience, and an ambitious worker with a few years of service may justifiably be dissatisfied with the limitations of his present job. There was a time when many of us wished to become policemen or railroad engineers, but our changing tastes have brought us into wholly different vocations.

The personal interview with the accident-prone worker may also bring to light forms of mismanagement, poor training methods, or unguarded conditions which had not previously been known. The contact between workers and their immediate job supervisors is of great importance, and constant check should be made to see that a type of supervision is exercised that will give the employees as wholesome an attitude as possible toward their jobs.

The plant interested in industrial psychology will also keep informed of the accident records of particular groups of persons. The physical surroundings of the workers may be partly responsible for bad records and should receive consideration. Uncomfortable working conditions are likely to create discontent and disturbed mental attitudes in general. For example, avoidable noise, poor light, unsatisfactory drinking water, unclean personal-service equipment, and impure air, all tend to cause annoyance and fatigue. The tired worker is usually the first to show irritation, which may be manifested by insubordination and disregard of safety rules.

It is sometimes necessary to control fatigue arising from other sources, too. Excessively long hours on a single operation (for some types of workers), rapid pace, insufficient rest periods, muscular overstrain, nervous tension, inefficiency,

and lack of training result in reduced output, spoiled work, and accidents.

Weariness is often associated with boredom and distaste for the job on hand—in fact, there is little to choose between physiological and psychological fatigue, so far as the respective results are concerned. The treatment, however, once the source has been determined, may be quite different. Fatigue of a physical nature is such as may be experienced by a farmer after sixteen hours of manual labor. It can be overcome by sufficient rest, sound sleep, and suitable food, and is usually productive of a strong, healthy body. Mental fatigue (better termed "staleness" or "strain") in industry is quite different and far more harmful. It is produced by work that puts a strain on one part of the body, to the exclusion of other parts. For example, an inspector may be tired from eye strain before his work day is done, and yet may have a large store of energy for a ball game after quitting time. It is from lack of proper exercise that he sometimes tires in the ball game and not from the work he has done during the day.

A change of employment, whether for an hour or two or for several months, is often as good as a rest. Many a person who has shown symptoms of a nervous disorder while working in a department filled with noisy machinery has fully recovered in the quiet inspection department on the top floor. On the other hand, a job of physical activity for a short period is refreshing to a person who is accustomed to sitting down and working only with hands and eyes.

Accident and production records have been improved by a few minutes of deep breathing and light exercise in the middle of the morning and afternoon work periods. For employees who are using up considerable energy, strength is sometimes quickly restored by a little sugar, and many plant superintendents have found it advantageous to have candy or other sweets distributed through various departments at some prescribed hour.

The work of the mental-hygienist is an addition to the usual accident-prevention program, which includes safety meetings, posters, mechanical and physical safeguarding, and first-aid training. This general activity, directed against the predominating accident causes of industry as a whole, is necessary, because the majority of men are more or less alike in their

habits. A warning against oiling or adjusting machinery while it is in motion will appeal to most employees. The worker who wilfully disregards a simple caution of this kind is the problem case that needs special attention.

We know that progress has been made when the accident and production records improve in a department, following the introduction of a new type of mental relaxation; and also when the mishaps of an employee who has previously shown a proneness to accidents become less frequent after he has been properly interviewed. If mental attitudes are the causes of most accidents, surely it would be worth while to devote more of our time to probing farther into this particular phase of safety work.

STATE HOSPITALS AS TRAINING CENTERS*

WILLIAM A. BRYAN, M.D.
Superintendent, Worcester (Massachusetts) State Hospital

IN any discussion of this subject, the first question that naturally presents itself is: What has the state hospital to offer in a teaching program for students? Some of the answers to this query are so obvious that a recital of them seems superfluous. But in order to bring out the point that I wish to make—that schools are missing a real opportunity in not utilizing state hospitals in their teaching—I feel it necessary to include even some of the more obvious reasons.

1. The physical plants and equipments of state hospitals represent a tremendous investment. Every state in the Union has one or more mental hospitals which are controlled by the government. It is uneconomical not to utilize them to the very fullest extent. To consider these institutions only as places where patients are segregated from the community is short-sighted. Medical educators frequently complain about the difficulty of obtaining certain clinical material. Yet few of them have given much consideration to the possibility of using the state-hospital population. It is rich in possibilities for medicine and surgery, as well as for psychiatry. It seems self-evident that the maximum return should be obtained from this investment.

2. A teaching relationship between state hospitals and medical schools would be a real contribution to public health. Since mental disease is one of the most serious health problems confronting us, it seems rather obvious that every agency which is interested in public health, such as the medical school, should be keenly alive to the necessity of coöperation in meeting it.

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3. The state hospitals have a wealth of clinical material that cannot be duplicated in any other kind of institution. There are approximately 350,000 patients under the charge of the mental hospitals of this country and at least 80 per cent of them are in state-owned institutions. These patients represent in some respects a cross section of the community population. While they are admitted for psychiatric reasons, they have a good many of the physical diseases that the medical student must see in order to get an adequate training for the practice of his profession.

4. Many patients in state hospitals remain under treatment over a long period of time. This enables the student to study the variations of behavior that so frequently occur in the same individual. The student who gets his psychiatric training only in the psychopathic hospital or in the psychiatric department of a general hospital is handicapped in this respect. He is not able, except in rare instances, to follow the psychiatric case long enough to see mood swings and other variations of reaction that are so striking in the psychoses.

Many psychopathic hospitals, because of their admission rate, have tended largely to become clearing houses. They are of limited bed capacity and the necessity for receiving the large number applying for admission makes it impossible to keep patients very long. They are rapidly transferred to state hospitals. Therapy is, therefore, often reduced to a minimum.

5. This clinical material is under strict control. Most of the patients are court commitments. Their daily lives are rigorously regulated by the hospital. With such control it is possible to study the individual with greater thoroughness than would be possible in the general or psychopathic hospital.

We have in these state hospitals great laboratories for the study of human behavior. They are already established and functioning. They could, with some changes, become valuable assets to schools that are interested in giving students a real course of instruction in the multifold aspects of disease.

I believe that the state hospital in the future will be an important factor in medical education. It will be utilized more and more by all agencies that are charged with the

responsibility of training the neophytes of the professions that are interested in human beings and their diseases.

But there is much to be done before such relationships can be established. Certain changes on the part of both hospital and school must be made before student training will be profitable. I am optimistic and believe that these changes will come and that a good rapport will generally be reached.

What changes should the hospital make? In presenting what I believe to be the deficiencies in both hospital and school, I give you my own opinion. Many psychiatrists will disagree with me. Some may even accuse me of exaggeration. It should be understood that I am talking in terms of general principles and policies. I have neither the experience nor the training to qualify me to speak on the techniques of education. I have no detailed scheme to present. But I believe that changes of attitude must take place in both hospital and school before we attack the problem of planning the details of student training.

1. State-hospital administrators must change their present attitude toward the field of psychiatry. There must be a recognition that further progress can come only with the acceptance, on the part of hospitals, of a greater responsibility to the community in matters of mental health. Their outlook must be broadened, must be less fatalistic toward the problem of mental disease, and they must get over their feelings of inferiority. It must be accepted that real progress cannot be made by constantly building more and bigger hospitals.

Administrators who spend most of their time considering problems of construction or the minor aspects of administration, and only a small part on plans for advancing the cause of psychiatry, must reverse this process. Hospitals must be administered in relation to the needs of the field as a whole rather than with a view toward mere individual business efficiency. The entire personnel of each hospital, lay as well as professional, must become psychiatrically minded and see in the work of the institution something more than routine detail.

The ultimate goal should be to make a contribution to society by reducing the incidence of mental disease. We must

make our hospitals centers to which individuals turn for help in the settlement of their health problems. We must be able to render a real service to the community. We should set out systematically and in an organized way to increase the prestige of the hospital to the point where the citizens of the state will follow its leadership in the field of mental hygiene.

The mental hospital must get away from its attitude of isolation. This has been one of the curses of hospital psychiatry since hospitals were first established. In my opinion, it is one of the reasons why psychiatry has been such a long time in being accepted by the medical profession. The medical school has not seen the possibilities in the state hospital largely because of this policy of isolation. If state-hospital staffs would take a greater interest in the problems of general medicine and of the medical school and would make some contribution to them, state-hospital psychiatry would enjoy a greater prestige.

The entire hospital must be reorganized with the immediate object of making the quality of psychiatric and medical treatment of patients the criterion of efficiency. To give custodial care does not, in my opinion, require well-trained psychiatrists. Good supervisors and ward attendants can do an excellent job in housing, clothing, and feeding patients. But in the kind of hospital I have in mind, these custodial activities are utilized by the psychiatrists as aids to other forms of therapy. The psychiatrist's contribution must go far beyond custodial care if he is to justify his existence.

In too many hospitals the writing of ward notes, regardless of their quality or the application they have to the recovery of the patient, is the ultimate aim and end of existence. Too often does hospital psychiatry consist of a mere diagnostic labeling of the patient, with little thought given to the therapeutic aspects of the case. Attendance at staff meetings will reveal the fact that much time is consumed in elaborate discussions about diagnosis, with little or no discussion about how to get the patient well. I believe in staff conferences, but only in so far as they lead to something more valuable than this.

2. Much more thought must be given to the selection and

training of personnel. Real psychiatric standards must be set up to be met by those who enter the hospital service, and men should be compelled to live up to these standards if they expect to remain. We must make a systematic effort to train our own people before we attempt to train students.

What have been the requirements generally for entry into the state-hospital service? Until recently they were very little more than a diploma from a recognized medical school. In many cases graduates were accepted without a general-hospital interneship. It is my belief that graduate psychiatric training must rest upon a foundation of good general-medical education. A general interneship should be a requirement for a staff position. Having been accepted, what psychiatric instruction did the new man receive? He was turned over to an older man for guidance, and from him the beginner received much information about the shortcomings of the institution, but very little about psychiatry. In the more advanced hospitals he was given a copy of Kirby, and certain books were recommended for him to read. It was hoped that he would draw some inspiration from within himself, that he would develop an ambition to read at least the *American Journal of Psychiatry,* that he would pay strict attention to what went on during staff meeting, and then it was prayerfully expected that the would-be psychiatrist might really become one. Such haphazard ways of training new staff members must give way to a well-planned, systematic period of instruction which, in my opinion, should precede a staff appointment. The graduate who does not care to take at least a twelve-months interneship in the psychiatric hospital as a preliminary to a staff appointment should not be considered worthy of such appointment. This organized teaching program must be carried on by men who are fitted for it and who have the time to give to it.

Furthermore, standards must be set for men who are already in the service. Certain questions should be asked at regular and frequent intervals about every man on the staff, to determine his quality and growth. Aside from questions about intellectual and personality characteristics, they should be concerned with his depth of interest in psychiatry as evidenced by his reading and study, his discussions, his

attendance at meetings, his acquaintance with developments in the field, and so forth. They should also cover his utilization of the facilities of the hospital for diagnosis and therapy, and his interest in research and advancement. If questions along these lines cannot be answered favorably, the hospital would be better off without such a man.

3. Better medical and surgical treatment must come before we are ready for the training of students. Better medical work will attract a superior grade of physician. But it must be more than an attempt to treat the incidental physical illnesses that develop in such large populations. This in itself is of considerable value to students, but the interest must be broader than mere pill-peddling. It must have as its ultimate goal the idea of throwing more light upon the relationship that exists between psyche and soma. It is perhaps for the student the best avenue of introduction to psychiatry.

4. The hospital that expects to train students must stimulate the desire on the part of its medical staff to do research, and this research must be made an integral part of the hospital program. When I speak of research, I do not necessarily mean the creation of great departments with special equipment and full-time men doing the work. What I mean rather is that an atmosphere of intellectual curiosity should be present. Such an atmosphere operates as an active deterrent to loose talking and little thinking. A healthy attitude of skepticism, a refusal always to accept, as authoritative, statements coming from so-called authorities, a desire to prove assertions susceptible of proof, an attitude of dissatisfaction with present knowledge, and a desire to develop new therapeutic techniques are all present in the institution that is interested in research.

5. When the institution is ready to accept the idea of community leadership, it soon discovers that well-organized outpatient clinics are indispensable. These clinics should be for both the child and the adult. They should be headed by men who have been trained for the work and who preferably can devote full time to it. It is only by means of such clinics that the hospital can take its proper place in a mental-hygiene program. The mental-hygienist must always take the state hospital into consideration in his work of prevention. It is

just as much a part of the function of mental hygiene to build up confidence in the state hospital as it is to spread information about the prevention of mental disorder. But the mental-hygienist can do little unless the hospital will accept its responsibility.

There is a second reason, if another is needed, why every mental hospital should organize these clinics. They are essential in training students. Psychoneurotics are not found in great numbers on the wards of these hospitals. Yet students must study such cases because these are the patients who most frequently are treated in private medical practice. They are numerous in the community, and if the people have confidence in the work of the hospital, they will come to the clinic where students may assist in their treatment.

6. In order to carry out these broader principles that I have outlined, hospital administrators must also recognize the fact that other disciplines as well as the medical profession have contributions to offer in psychiatry. Mental hospitals should not neglect in their teaching programs the opportunities that come from recognizing students of other professions who are capable of making a real contribution. We must be in a position to recognize all sound new thought in psychiatry. We must welcome the representatives of the social sciences and invite them to utilize the facilities of the institution. I am more and more coming to believe that the sensible approach to the problems of psychiatry in our present state of knowledge is a coöperative one with the other professions.

7. Before any teaching program can be embarked upon, it must be well organized. It is not sufficient to invite the student to this wealth of clinical material and let him browse around at will. A well-organized and well-thought-out program of teaching is essential if students are to be properly trained and the clinical material utilized to its best advantage. There must be in the hospital a full-time clinical director or other person whose main function is to teach both personnel and students. This teaching program cannot be built around any one school of thought. We cannot give that well-rounded training that should be a part of any study of human behavior if we educate along one line only.

The hospital administrator must be able to see in student training an unusual opportunity to participate in this broader

program. He is only too apt to look at such training as a chance to get some additional personnel without paying for it. Traditional hospital administration is upset by the presence of students. They are a liability from this point of view. They create new administrative problems. That they make a real contribution to the hospital—sometimes only in an intangible, subtle way—is lost sight of. The mere presence of a group of young students, enthusiastic, full of ideals, intellectually alive, does more to prevent institutional stasis than anything else that I know of. They afford a constant stimulus to the members of the staff to better their thinking and to be constantly on the *qui vive*. The hospital must be interested in the student as a student and not as one who is there to do the "scut work."

In this somewhat sketchy outline of what I believe is a primary requisite to any attempt at student training, I have tried to make it clear that what I believe must first be changed are attitudes and policies. Until hospital administrators are thinking along different lines from those that have concerned us for a good many years, we are not prepared to take up our share in this work.

While it is true that the state hospital must make certain changes in its organization and general outlook, it is equally true that the medical school has some deficiencies to overcome before a proper working relationship can be established. It seems to me that a certain amount of blame must be borne by the school itself in the failure to recognize the possibilities existing for student training in the state hospital.

First of all, the school must be willing to recognize that a proper course in psychiatry is an essential part of the medical curriculum. Unless educators realize that a knowledge of the emotional and intellectual life of the individual is an indispensable part of the training of the medical student, there is little use to continue any discussion about the matter. If the school thinks in terms only of the science of medicine and not of the art, nothing can be done. As the matter now stands, the course in psychiatry in many medical schools consists of a series of dry lectures on Kraepelinian psychiatry, supplemented by a certain number of clinical demonstrations which are usually looked upon by the student as a fairly good vaudeville show.

With this background, is it any wonder that comparatively few graduates are attracted to psychiatry? Is it strange that the medical man sees nothing in psychiatry that is of particular value to him? Why should he, when he has been given little or no insight into its possibilities during the period when he received his formal education? It is a significant fact that many men in general medicine tend to boast that they know nothing about psychiatry. The medical school must get some insight into these matters and be willing to extend that degree of importance to psychiatry that some of us believe it deserves. Seemingly it has not been emphasized by the leaders of medical education that in a better knowledge of the mental and emotional life of the sick individual lies the answer to the ever-increasing menace of the cults. These cults have sprung up in response to a need on the part of people. What good will the attempts to legislate against them do when this demand cannot or will not be met by our profession? The hypochondriacs, the neurotics, the neurasthenics have been crying to us for attention for years, but because their maladies cannot be physically demonstrated, the medical profession has turned a deaf ear to them. The medical school must be willing to make a real effort to correct this situation before psychiatric education can progress very far. As I see the matter, there are three groups of students who should get training in psychiatry. The first group is made up of the undergraduates, and I am very much of the opinion that every medical student should get a grounding in the social sciences, regardless of whether or not he ever intends to follow psychiatry as a specialty. It seems to me that the courses in the basic sciences should be accompanied by courses in the social sciences upon which psychiatry is based. The contact of the undergraduate with psychotic cases must necessarily be a very brief one, and probably would be only an exposure to psychiatry as practiced on the wards of the well-organized mental hospital. The second group consists of those graduates who desire a psychiatric interneship after their general interneship, even though they intend to follow some other specialty. They see the necessity of a well-rounded training. The third group consists of those graduates who have completed their general interneship and wish to follow psychiatry as a spe-

cialty. It is for the last two groups that the state hospital has a real place in the educational scheme.

It would seem that the school, in addition to correcting these shortcomings in the matter of teaching psychiatry, should set up definite standards that must be met by hospitals that desire to participate in medical education. The school should assume the responsibility of pedagogic leadership and should give every assistance to a hospital that is trying to meet its requirements. In certain instances, where schools and hospitals have set up a working relationship, there is little attempt on the part of the school to guide the institution in its teaching program. Presumably the school is the pedagogical expert and should make every effort to get the teaching in the hospital upon a sound basis. As I see the responsibilities of each organization, it would seem that the part of the hospital in this program would be to teach the student the practical application of the theory that he received in his school. If the hospital professional staff does not know of the theory he is receiving, it is hardly to be expected that any integration between these two aspects will result. It would seem that one way of making this instruction continuous would be to utilize the services of state-hospital staff members as a part of the faculty of the medical school. Certainly the man who takes the responsibility of teaching students on the wards of a hospital is as much entitled to this recognition as the individual instructor who lectures to students. He has a real contribution to make even in the theory of psychiatry.

The school must be willing to throw the weight of its prestige and influence to such hospital organizations as are assisting in medical education by furnishing the clinical material. It must do this by assuming the leadership that I have discussed above, and by assisting the hospital to secure the proper kind of personnel. This it can do by encouraging its students to enter the hospital service in order to gain further experience. This cannot be a one-sided arrangement. School and institution are dependent each upon the other and there must be real coöperation or a successful working relationship cannot exist. The school cannot teach psychiatry alone, and in many cases this has been attempted. Schools have given their students only textbook psychiatry. This seems to me fully as absurd as it would be to try to teach medicine or

surgery out of books without showing the student any actual cases.

I have attempted to offer a partial analysis of the psychiatric situation as it exists in relation to the problem of medical education. I agree that I have discussed these matters rather summarily, but I feel that there is a crisis in psychiatry which requires action. To recapitulate, I am enthusiastic about the possibilties that exist in the state hospital for the instruction of students, but as I have endeavored to point out, these possibilities cannot be realized to the fullest extent until certain changes of attitude are made by both hospital and medical school. In this discussion I have confined myself to the medical school, and what I have said about medical students might be said about the students of schools of all other related disciplines. It must be confessed, however, that the schools that train social workers, psychologists, sociologists, and workers in other social sciences have been more alert to sense these state-hospital possibilities than have medical schools.

WHAT MENTAL HYGIENE MEANS TO A COMMUNITY *

SIMON STONE, M.D.

Psychiatrist, Manchester Mental Hygiene Clinic, New Hampshire State Hospital, Concord, New Hampshire

THE organization of a mental-hygiene clinic represents an individual problem, to be adjusted to the needs of the community, the number of patients, the funds available, and the problems encountered. A description of the functions of the clinic in Manchester [1] gives an adequate index of what mental hygiene can mean to a community.

The clinic consists of a director, two assistants, a psychologist, a social worker, and a secretary. The entire staff, except the secretary, is part of the state-hospital staff, while the services of the secretary and the quarters are supplied by the District Nursing Association of Manchester. Besides the clinic in Manchester, a number of other clinics are held by the state-hospital staff, in Nashua, Dover, and Portsmouth, while the opening up of a few more clinics is being contemplated as soon as additional funds become available.

The Manchester clinic has been in operation for over three years. It is held at present once a week, and an appointment is required before a patient is accepted at the clinic. The ages of patients range from one to sixty. The patients are usually referred to the clinic by various social agencies in the city. The following agencies have taken advantage of the services of the clinic and have referred patients for study and treatment:

1. The Children's Aid and Protective Society
2. The District Nursing Association
3. Public-health nurses
4. The Boys' Club
5. Private agencies and Homes
6. Police courts

* Read before the Nursing Alumnæ Association of the New Hampshire State Hospital, Concord, New Hampshire, March 28, 1934.

[1] Manchester is the largest city in New Hampshire, with a polyglot population of about 70,000. It is also the largest manufacturing center in the state.

7. School principals
8. Physicians confronted with neuropsychiatric problems
9. Friends of patients who have heard about the clinic from others who have benefited from its services.

The absence of any diagnostic neuropsychiatric centers in the state has caused the resources of the clinic to be widely sought. Besides serving Manchester, the clinic has drawn patients from communities within a radius of seventy miles of the city. Every patient admitted to the clinic is given a physical examination, psychological tests, and a neurological examination. Clinical and laboratory studies are carried out when indicated, although frequently more extensive laboratory studies cannot be made because of lack of facilities. If the patient is accepted, he is asked to return at definite intervals for treatment. Non-acceptable cases are disposed of by notifying the referring agency of the results of the examination and offering suggestions as to treatment.

A study of 100 consecutive cases admitted to the clinic disclosed some interesting data as to types of disorder, treatment, and results. Children of from two to fourteen years constituted about 80 per cent of all admissions. Fifty-three per cent were referred to the clinic because of behavior disorders of sufficient severity to attract the attention of teachers, school principals, or interested agencies and to call for psychiatric aid. Ten cases suffered from convulsive seizures, alone or in combination with personality disorders. Mental deficiency, with an I.Q. low enough to warrant suggestion for placement in a school for the feebleminded, in some cases also associated with difficulties in adjustment at home and in school, was encountered in ten cases. The psychologist's estimate as to the patient's ability to carry on with his school work, the need for placement in special classes or for institutionalization, was found very helpful in this group of cases. In some instances a mentally deficient child was being urged to carry on school work beyond his intellectual capacity, thus acting as a drawback to the other children and a source of annoyance to the teacher, while the child's failures and frustrations frequently expressed themselves in abnormal behavior in school and at home. Placement in special classes whenever possible, suggestions to the teacher as to the easing off of the school work, or even complete

removal from school were found helpful. Institutionalization in a school for mental deficients was used only as a last resort.

Frank neurological conditions, some associated with difficulties in adjustment, brought ten patients to the clinic. Among them were included one case of dystonia, three cases of maladie des tics (one of them with mental changes that will be taken up in detail), one mild atypical post-encephalitis case, one case of facial paralysis, and one case of narcolepsy. The latter condition had existed for years and the patient was often blamed for falling asleep in classes and was treated by being walked around the classroom by his classmates. Under ephedrine a striking improvement was noted in his condition.

Several cases of glandular disturbances of the thyroid and pituitary were also included in this group. Two cases were referred by the courts, for suggestion as to their disposal. The remaining cases consisted of frank psychoses or conversion neuroses, in several instances requiring institutionalization.

One of the major handicaps of an out-patient psychiatric clinic is the limited amount of time at the psychiatrist's disposal. The patient is seen once a week and only from twenty to thirty minutes can be devoted to an interview. The psychiatrist usually sees from eight to ten patients in an afternoon, including one or two new cases that often require a physical and a neurological examination. It is true that some cases are referred only for diagnosis, but the majority, especially those cases that require active psychotherapy, are frequently treated more by suggestion than by extensive psychotherapy. Even partial analysis cannot be attempted because of lack of time. Not infrequently conferences with relatives, referring agencies, and social workers are also included in the same afternoon.

In treatment, the question of placement comes up regularly. The feeling that a change of environment may have a favorable influence upon the patient's progress must often be disregarded. Whenever possible, the clinic aims to adjust the patient to his environment, even if it is not always satisfactory. The maladjusted child, unless steps are taken to correct wrong slants, will find it difficult, at times impossible,

to adjust himself in a new environment. Placement, then, is not always feasible and is utilized as a last resort, when the environment is hopelessly bad; in such cases it often solves the problem satisfactorily.

Behavior disorders in children, as is evident from the percentage already given, make up the largest number of cases. The child's delinquency or odd behavior is often a revolt against an environment that the child considers hostile or too difficult to conquer. Often it is through abnormal behavior that the patient succeeds in receiving some attention, even if it is of the negative kind. Sometimes all the young patient needs during such critical periods is a sympathetic elder friend to whom he can confide freely his doubts and fears, and in whose authority and knowledge he has implicit confidence. The psychiatrist in the clinic serves this purpose admirably; but so would also the psychiatrically minded family physician. Friendly counsel and authoritative suggestion will frequently, in the average case, help the child over this period of stress until he regains his self-confidence and is able to carry on satisfactorily without any assistance. In several cases the behavior disorder was found to be a direct accompaniment of an organic brain condition. Treatment and improvement in the organic condition have favorably influenced the child's behavior. Psychotherapy also has had a favorable influence on some of the organic symptoms.

The sensitive child frequently reacts to new stimuli by an excessive state of inhibition. Change in teachers, schools, or classmates may evoke a state of aversion, negativism, refusal to partake in school activities, and general breakdown. The following case, quite typical of this group, is a good example of this type of reaction:

> **E. T., a thirteen-year-old schoolgirl, was referred to the clinic by the school nurse for the following reasons: (1) she was extremely nervous; (2) she suffered from temper tantrums; (3) she was seclusive, stubborn, refused to attend school; and (4) she would not eat, and was given to crying spells.**
>
> **These symptoms were noticed after the family, because of financial difficulties, had had to change their mode of living and move to a smaller town, where the patient found herself a stranger.**
>
> **E. T.'s past history contributed nothing except the fact that she rarely confided her plans to her mother and was considered rather stubborn and given to strong likes and dislikes. Her school work had been satisfactory up to the year in which she was referred.**

Her present difficulties were of one year's duration. After the family moved, she found it difficult to make friends in her new school. At first she appeared upset and balky and complained of headaches. She imagined that children were looking at her and were making fun of her recitals. In the classes she would daydream; when asked to recite, she would burst into tears. At home she would stare into space and refuse to share her meals with her family. An attempt to return her to her former school did not improve her condition. She attempted to run away from her mother on several occasions.

In the clinic she appeared surly, morose, and uncommunicative. She was a pleasant-looking young girl, slightly tall for her age. It was difficult to establish a contact with her and the conversation was at first carried on by the psychiatrist most of the time. She explained her situation as follows:

"I did not care for the teacher much. She used to frighten me and scold me. I was very happy in our old place. I used to try to do things for the teacher and would stay after school, but still she did not like me and this troubled me. When it came to learning history, it came sort of hard for me, and I began to be afraid that I could not learn it and recite well, and then it came to me that probably the children would make fun of me, and when I would get up and recite, I would think of that and begin to cry. I would get a headache and kind of a funny feeling would come to my throat. Then at times my stomach would feel queer. When I would try to study, the same thing would happen, and I would begin to think about the teacher and the fear of not doing well in reciting, and then I could not learn my lesson at all and finally would only hate school."

Treatment consisted of a temporary lay-off from school for several weeks. The teacher was interviewed and the patient's condition explained to her. At succeeding interviews her relationship to the teacher and her unfounded fears were explained to the patient. Later she was willing to attempt school again. Interest in sports was aroused in her. After six months, lack of spontaneity and some seclusiveness were the only symptoms remaining. Election to the vice-presidency of her class has allayed her remaining fears and ideas of inferiority. When seen in the clinic six months after the last interview, she appeared well adjusted, was doing excellent school work, and showed a normal interest in her environment.

Treatment in this case was based entirely on suggestion. The psychiatrist spent his time in talking to the patient, analyzing her difficulties, and pointing out the solution. The coöperation of the patient's mother, her teacher, and the school nurse helped considerably in hastening the improvement.

In several cases that showed similar reactions a temporary or permanent removal from school resulted in a satisfactory adjustment. The latter method was resorted to only after consultation with the psychologist, who felt that the patients were carrying on school work beyond their intellectual ability. With the burden of school work removed, the behavior difficulties gradually dwindled away. In another instance, in

which conversion symptoms were quite prominent, they disappeared after the patient was made to give up an after-school job that indirectly was responsible for a slump in her school work. Under psychotherapy her ideas of inferiority and lack of self-assurance ceased to trouble her.

Mental disease in children is mainly a result of the interaction of two major factors—poor stock and a poor start. Nowhere is this more evident than in a mental-hygiene clinic that deals with behavior problems in children. A child coming from poor stock very often makes a good adjustment in life if the early training and environment are suitable. A child of poor stock with a poor start has all the odds against him. Early attention to wrong slants, with accompanying change in environment, will often bring a change in personality; the older the child, the more difficult the problem becomes. Several cases of this type were encountered in the clinic, with the problem of delinquency complicating the case. Where it was felt that the clinic could not accomplish much because of the poor home environment, placement had to be resorted to. The majority of patients, although they failed to adjust themselves even after a number of visits to the clinic, found it rather easy to adjust themselves in various homes or farms like the Coit House, Golden Rule Farm, and Home for Little Wanderers. Some time, however, usually must be allowed to elapse before the results can be finally judged.

M. C. is a good illustration of a patient in this group. She was twelve years old, with an I.Q. of 80. She was referred to the clinic by a former housekeeper of her father's, whose own son had been benefited by treatment in the clinic. The patient's mother was dead; her father, a truck driver, was busy all day, leaving the care of his three children to a housekeeper. The reasons for the patient's admission to the clinic were: (1) she was profane in her talk and told obscene stories to other children; (2) she stole candy from neighboring stores and chocolate stains were often found on her underwear; (3) she was very slow in her housework, and very careless about her clothes and personal appearance; and (4) several housekeepers in her father's employ had had to leave because of inability to get along with her.

An attempt to adjust the patient at home in her old environment failed. Her father disliked the child, as she had caused him a great deal of difficulty with his housekeepers, of whom she had been quite jealous. He was rather anxious to have her placed away from home. After several visits at the clinic, where she continued to tell many stories that were untrue about her father, his housekeepers, and their maltreat-

ment of her, it was decided to place her in a special home, where she is located at present and is adjusting satisfactorily.

As placement is not always possible, the problem of adjusting the patient to his environment, even if very unfavorable, frequently comes up.

R. I., nine years old, was referred by the Boys' Club, because of fighting habits, inability to play fair with other boys, enuresis, and excessive bragging.

Here again home conditions were found to be very unsatisfactory. The patient's mother had deserted the family four years earlier, leaving R. I. and a younger brother and sister. R. I. was disliked by his father because he greatly resembled his mother. A young housekeeper hired by his father was entirely indifferent to the children.

In the clinic R. I. had a hangdog attitude. He disliked to discuss family matters, and when his mother's reasons for leaving her home were brought up, he remarked angrily, "She is my mother, isn't she?" Under psychotherapy, after a number of visits to the clinic, his behavior gradually improved for the better. He was still attending the clinic when his father moved away and the clinic lost contact with him. In this case a fairly satisfactory home adjustment was effected, although placement would possibly have been a more satisfactory solution could it have been more easily brought about.

Epileptics present quite a distinct problem. They supply about 10 per cent of all admissions and the majority of them are under the age of sixteen. They fall largely into two groups:

1. The deteriorated epileptics, of low intelligence, who usually are also suffering from frequent seizures. Treatment of this group at home is rather difficult and commitment to an institution is the most satisfactory solution.

2. The non-deteriorating group, with normal intelligence. This group also includes cases in which the diagnosis of epilepsy was made incorrectly outside the clinic. Emotional factors are frequently found to complicate the epileptic picture, and their removal almost always favorably influences the course of the seizures. In every case suffering from convulsive seizures, an attempt is made to determine the exact etiology and also the rôle played by the patient's emotions in precipitating the attacks. It has frequently been found that before coming to the clinic the patient's family has expended large sums of money on various medicines, usually bought from supply houses, in an attempt to cure the condition. On numerous occasions the clinic was consulted in regard to

medical quacks, who had advertised their success in curing epilepsy, and the advisability of consulting them. Wherever possible, the family is urged to care for the patient at home if the seizures are becoming infrequent under treatment. The clinic has also often supplied medication free of charge to patients who could not afford to buy it outside. One stipulation is always made when the drug is supplied free of charge—that no patent drugs for the cure of epilepsy be bought elsewhere. In this group of cases many patients are able to carry on at large without need of hospitalization, much to the gratification of their families.

In determining the cause of the seizures, the clinic again is handicapped by lack of hospital facilities for keeping patients under closer observation and for laboratory studies. Spinal-fluid studies, although indicated in a number of cases, especially where juvenile paresis or neoplasms are suspected as cause, are not being carried out for the above reasons. The establishment of a children's ward in the state hospital—as yet a dream of the future—would satisfactorily answer this need. Mild hypoglycemia was suspected as a cause in several cases and improvement under increase in sugar intake resulted there. Thus it is important that in every case of epilepsy every phase should be considered, the emotional as well as the organic, and that other systems should be investigated besides the nervous system.

The following cases serve as examples of this group of patients:

R. P., eleven years old, was referred to the clinic because of fainting spells which were diagnosed as epilepsy. His mother also complained that the patient was nervous, fidgety, and very finicky about his food, for which he was frequently punished by his father.

R. P. was an underdeveloped, undernourished, pale youngster, who appeared younger than his age. He had had about four seizures, atypical in character. They usually occurred while he was out playing with his friends, boys much older and stronger than himself. Things would go black before his eyes, and he would fall down in a faint, but he did not exhibit any convulsive movements. He always had had a strong craving for sweets, although his mother was afraid to let him indulge in sweet foods, as she felt it was harmful. In the clinic the mother was given directions as to the patient's diet, his sugar consumption was increased, and an attempt was made to straighten out his emotional difficulties. He has not had any seizures for six months and the family has reported a striking improvement both physically and

mentally. Whether the seizures were purely psychogenic in origin or also due to a mild hypoglycemia, still remains a question.

The next case is illustrative of a case of "epilepsy," again of uncertain etiology, in which temporary hospitalization in the state hospital was agreed to by the family because of the difficulties involved in caring for the patient at home. Again improvement was obtained without any medical treatment except a lumbar puncture.

A. L., an eleven-year-old boy, was referred to the clinic because of unmanageable behavior at school. In the daytime he was very nervous and fidgety, unable to hold things in his hands. He seemed to disregard all rules for safety—would jump in front of running automobiles, not seeming to realize the danger. At night he had spells when he became unconscious, "rigid," and suffered from bad dreams. The above symptoms had come on about two years before A. L.'s admission to the clinic, following an injection of diphtheria antitoxin to which the patient had apparently become sensitized through a previous injection of toxin-antitoxin. At that time the teacher also reported that he appeared very sleepy in his classes.

It was impossible to treat A. L. satisfactorily in the clinic, and he was, therefore, admitted to the state hospital for observation. The convulsions were mainly tonic in character and were at times followed by confused and excited periods. Following a lumbar puncture and the removal of 10 cc. of spinal fluid, the patient ceased to have any seizures. His conduct also improved markedly following the puncture. Undoubtedly the ward discipline was also an important factor in improving his behavior as he was considered a model patient on the ward at the time of his transfer to the Laconia State School for the Feebleminded because of a low I.Q.

In this case a mild post-vaccinal encephalitis, probably of anaphylactic origin, was considered as the major cause. The patient's nervous system had been rendered unstable by an attack of chorea shortly before the injection of the sensitizing dose of antitoxin.

The following case illustrates the importance of emotional factors in increasing the number of seizures:

R. M., an eight-year-old girl, was referred to the clinic because of frequent petit and grand mal attacks of several years' duration. Neurological examination was non-contributory except for a horizontal nystagmus which was of congenital origin. Seizures were less frequent on Sundays and holidays. R. M. had an I.Q. of 50, according to the psychologist, and was expected by the teacher to do work beyond her intellectual ability. She had to walk to school about one mile daily and this seemed to tire her. Luminal failed to relieve the seizures, but the removal of tonsils and adenoids and taking the patient out of school reduced the number of seizures so that at present they occur at very long intervals.

Frank psychotic cases are frequently referred to the clinic by the attending physician or a social agency for diagnosis and possibly treatment. Usually a single interview is sufficient for establishing a diagnosis. The case, if recognized early and if the possibilities of adjustment in the community are good, is asked to return to the clinic at intervals for treatment while allowed to remain at large. Suggestions for commitment, whenever required, are made to the referring agency, relatives, or physician. Thus a number of cases that would otherwise require commitment to a state hospital are allowed to remain at large, although they display definite symptoms of a psychosis. Adults supply the majority of cases in this group and in numerous instances the patients have agreed to come in as voluntary patients to the state hospital, where they have benefited from intramural treatment and more extensive studies have been possible.

This group also includes several cases of conversion neurosis in adults with a strong invalid reaction, which were treated in the clinic very successfully. The cases of neurosis that were not benefited were urged to enter the hospital for further observation, especially where dementia praecox in its early phases was suspected. The treatment of conversion neurosis is simpler in patients with normal intelligence, with whom a frank discussion of the problem is possible.

W. S., a twenty-year-old white female was referred by the Children's Aid and Protective Society for the following reasons: (1) she was afraid to walk in the streets alone; (2) she had been having heart attacks, anemia, and loss of strength; and (3) she had not worked for over a year and was perfectly satisfied to remain an invalid and dependent on her family.

Investigation of the family disclosed that the parents, Polish immigrants, objected greatly to their daughter's American ways. This was especially the case with the father, who disliked the girl's friends and took delight in scolding her for associating with them. W. S.'s difficulties were of gradual onset, beginning with neurasthenic signs which were later followed by gradual withdrawal. She finally felt ashamed to meet her old friends, who were earning money. Her physical complaints became accentuated as a defense reaction against the family's disdain because of her loss of earning capacity.

In the clinic the patient was given a thorough physical examination and it was impressed upon her that nothing physically wrong was found. Gradually her difficulties were analyzed and she was given to understand the cause of her physical complaints. The social worker has helped in establishing some rapport with the family. In this case an attempt was made to render the patient tough-skinned against the

remarks of her father. She was urged to find a position, and finally secured one. At the time she was discharged from the clinic most of her fears had disappeared and she had been occupied steadily for about six months.

Early dementia-praecox cases will frequently parade under the guise of a neurosis, and several cases of this type have been under treatment for long periods in the clinic, with admission to the state hospital for more active treatment as the final solution.

Delinquents are usually admitted to the clinic by recommendation of the court, police officers, or other interested agencies. Delinquency in children is usually a result of maladjustment, and at times appears the only logical reaction to an unsatisfactory environment. Wherever possible, if the patient is intelligent, treatment is carried on in the clinic. Commitment to the industrial school or placement elsewhere under supervision is rarely resorted to and then only when the occasion demands it. Several boys were referred because of writing blackmail letters to various people in town for the sake of obtaining extra money. Investigation of the environment disclosed that the cause lay there. Recommendations to the referring agencies and suggestions for treatment are made after the cause is investigated in the clinic.

The mimicking of one child by another, notably where one is suffering from some form of muscular incoördination like tics, spasms, choreic and athetoid movements, or stuttering, becomes quite a problem when the children happen to live under the same roof. Usually it is the younger child that mimics the older, and the problem of separation comes up in cases of this kind. The following case is illustrative of this type:

H. L., a ten-year-old boy, was referred to the clinic by the Children's Aid and Protective Society because of excessive stuttering, nervousness, blinking of the eyes, biting of the finger nails, sniffling, and twitching of the shoulders. A diagnosis of maladie des tics was made. The patient's younger brother, of five years, was also referred because of nervousness, restlessness, inability to articulate clearly, vomiting spells, and temper tantrums. While a marked improvement has been noted in both under treatment, the original symptoms of the younger have disappeared completely except for the fact that off and on he is brought into the clinic because he is mimicking the various tics of the older one. Although the children are much attached to one another, the advisability of separating them is being strongly considered. Several other cases of a similar nature, involving mental rather than physical factors have cropped up in the clinic.

A clinic can function successfully only when its personnel is interested in the problems presented by the patients, and when the importance of the clinic's contributions to the mental health of the community is appreciated both by physicians and laymen. To the physician the clinic offers the services of men trained in handling problems with which the average practitioner of medicine is unfamiliar. It does not promise a cure for every case referred, but it does offer the most satisfactory solution under the circumstances for problems that would otherwise remain unsolved. Charitable organizations appreciated the value of these clinics before the general practitioner did, the latter still probably being afraid that the clinics may encroach upon his domain. The state is primarily interested in developing these clinics, as only through them can early diagnosis and successful treatment of mental disease be effected.

The death rate from tuberculosis has dropped considerably since the prevention campaign against this disease was organized. On the contrary, the number of patients admitted yearly to state hospitals is increasing, so that at present almost half of the total beds in the country are occupied by mental patients. The state hospitals of the country are confronted with the dilemma whether to increase the number of beds for intramural treatment or to expand their activities extramurally and through prevention of mental disease accomplish the necessary savings. State hospitals are rather handicapped at present in the expansion of their mental-hygiene programs because of shortage of funds. A clinic in Concord is in contemplation when additional funds become available; clinics for several other towns are also being planned for the more distant future. Problems in mental hygiene vary in different communities. Psychiatrists working in a clinic of the Manchester type are required to deal with a larger variety of problems because of the large number of organic cases involved. Besides being a therapeutic center, the clinic also becomes a clearing house for a number of problems not directly connected with mental hygiene. Neurologic problems are frequently referred for diagnosis and treatment because of lack of other such diagnostic centers in the state.

A crying need of the clinic is a children's ward in the state hospital, or connections with the pediatric department of a

general hospital, where some of the problem cases that require closer observation could be kept for a definite time. Lack of laboratory facilities makes diagnosis at times very difficult. Watching the child unobserved while he works and plays will frequently give more insight into his difficulties than hours of talk and questioning at the clinic. The abilities of the child to get along with other children could also be studied firsthand.

From the accounts of the cases given above it will be seen that the clinic has a number of functions to perform. The psychiatrist, in branching out into the community, is trying to perform a service owed to it by the state, at the same time asking for coöperation from interested persons in the community. He is not trying to preach that all forms of mental disorders can be cured by a few visits to the mental-hygiene clinic. His aim is to point out to physician, teacher, social worker, and judge what service he can offer in the problem cases that come to his attention. The clinic is not going to increase the intelligence of the feebleminded, but it is capable of adjusting some of the emotional difficulties that account for the maladjustment in certain cases.

Psychiatry has ceased to be an institutional profession. Both for his own benefit and that of others, the psychiatrist is becoming more involved in extramural activities, invading generally all branches of medicine for mutual benefit. Neuroses are the bane of every practitioner and frequently only the psychiatrist can successfully cope with them.

The psychiatrist in a mental-hygiene clinic is, however, handicapped by lack of time. He has little opportunity for missionary work in the community in the cause of mental hygiene. This chance is grasped by various cultists and others who, seeing the lack of initiative of the psychiatrist, consider the problems as rightfully belonging to them. More often these problems go entirely unattended. Every community, large and small, can boast of a number of such mental-hygiene problems which, like Pirandello's six characters in search of an author, are waiting for some public-health nurse, teacher, social worker, or police officer to become sufficiently interested to notice that the child requires psychiatric attention and to refer the case to a mental-hygiene clinic for treatment.

THE PROBLEM OF THE DEFECTIVE DELINQUENT*

MILTON HARRINGTON, M.D.
Institution for Male Defective Delinquents, Napanoch, New York

THERE is, in all of us, a strong and deeply rooted tendency to avoid those forms of action which are productive of discomfort or pain. Society takes advantage of this fact in attempting to control the behavior of its members. The penalties imposed for crime represent efforts on the part of organized society to check antisocial behavior by making the results of such behavior disagreeable. And there is no doubt that these efforts have met with a very considerable degree of success. In spite of all that one-sided theorists may say to the contrary, common sense and every-day experience go to show that punishment does deter. Without punishment for antisocial behavior, organized society could not continue to exist.

But, although up to a certain point punishment proves successful as a means of preventing crime, it does not prevent it in every case. There are certain people who are not deterred from criminal behavior by the fact that crime does not pay, and most of the inmates of our prisons and penitentiaries are people of this class. Now these individuals who are incapable of shaping their conduct in conformity either with their own personal interests and needs or the needs of society, who react to the situations of life with unsatisfactory and pain-producing forms of behavior which other people tend to avoid, are to be looked upon as mentally abnormal, just as are those whom we are accustomed to speak of as insane. These also are cases for psychological study and treatment. Amongst these abnormal individuals who make up the criminal class, we have a large number who are feebleminded. In this paper, I wish to discuss in brief outline the mental-hygiene problem that these feebleminded criminals present. First it will be necessary to consider the causes of their delin-

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quency, and then we may pass on to consider the problem of its prevention.

CAUSES OF DELINQUENCY IN THE MENTAL DEFECTIVE

The mental defective is in greater danger of falling into crime than is the person of normal intelligence, and the reasons for this are not hard to find. In the first place, he is less able to appreciate the differences between right and wrong, and so is less likely to be deterred from wrongdoing by conscientious scruples. In the second place, he is less able to appreciate the dangers of detection and punishment to which he exposes himself when he commits a crime, and so is less likely to be deterred by fear. In the third place, he is apt to be suggestible and lacking in self-control, and so is predisposed to crime, not merely from failure to see the danger ahead, but also from inability to apply the brakes and keep from running into it.

But in addition to these constitutional factors which render the mental defective more liable to commit crime than other people, there are also certain environmental factors that must be taken into consideration; for the mental defective is very likely to grow up in an environment that is not suited to his requirements and a large part of his antisocial behavior is to be attributed to this fact. In considering the environmental factors that make for criminality in the mental defective, it will be convenient to divide our defective delinquents into two groups—a rural group and an urban group. Of these, the urban group is the larger and more important, and we shall, therefore, give it first consideration.

The environmental conditions that operate to give rise to crime or delinquency may be considered under four headings: (1) the home, (2) the neighborhood, (3) the school, and (4) conditions of employment. Let us consider these four factors in the order in which they are here named.

1. *The Home.*—The importance of the home in the formation of character is so generally recognized that it would be absurd to discuss it. The only question we need consider is, What kind of home is the mentally defective city dweller likely to have? Is it likely to be one that will make for good citizenship or one that will make for crime? Mentally defective children, as we know, are commonly the offspring of men-

tally defective parents; and the mentally defective parent as a rule has not the earning capacity to maintain a home for his children that will afford them wholesome living conditions; neither has he the personal habits and ethical standards that will make him a good example to his children, nor yet the self-control and understanding to instruct and discipline them. In short, the mental defective has as a rule none of the essential characteristics of a good parent, and the home training that he will give his children is likely to be very bad for this reason.

2. *The Neighborhood.*—Although perhaps of less importance than the home, the nature of the neighborhood in which a child grows up is nevertheless a potent factor in shaping his character. The great importance of this factor is clearly indicated by the sociological studies of Shaw and others, which go to show that the delinquents in our big cities come mainly from certain slum areas which serve as breeding grounds for crime.

Now in what kind of neighborhood is the city-bred mental defective likely to grow up? Will it be a desirable neighborhood or the reverse? The answer is obvious. The feeble-minded child, as I have just pointed out, is in a large percentage of cases the offspring of feebleminded parents, and the feebleminded parent, partly because of his poverty and partly because of his tastes and tendencies, is very likely to gravitate to the slum districts in which criminals are bred. [So not only is the feebleminded child likely to have a bad home environment, he is likely to have a bad neighborhood environment as well.]

3. *The School.*—Whether any given environment or experience proves valuable or the reverse will depend largely upon the nature of the person who is subjected to it. *What is one man's food is another man's poison.* On the average boy of normal intelligence, the ordinary public school exerts a wholesome influence, giving him useful knowledge, mental discipline, and habits of industry. But what does it do for the mental defective? Being unable to understand the subjects that go to make up our ordinary formal education or to do the work required of him in the ordinary classroom, and being, moreover, prevented by the restrictions of the classroom from engaging in those forms of work which are suited to his

capacities, the mental defective in the public school does little work of any kind and so develops habits of idleness. Being idle, he gets into mischief, and is subjected to rebuke and punishment. Then, because he is constantly in trouble with his teachers and cannot do the work demanded of him, he develops a dislike for school and plays truant as a means of escaping from what is for him an intolerable situation. So he becomes a street loafer, is thrown into association with bad companions, and presently, as a result either of his truancy or some form of wrongdoing to which it has led, he is arrested, taken into court, and perhaps committed to some institution for juvenile delinquents. So the outcome of his schooling is that he presently finds himself in the ranks of the law-breakers and comes to look upon the representatives of the law as his enemies.

4. *Conditions of Employment.*—Lack of regular employment is unquestionably one of the chief factors in the causation of crime. When a person either cannot or will not work, he is likely to be driven to steal as a means of obtaining a livelihood. Also, being idle, he has plenty of time to get into mischief. The person who is usefully employed is not likely to steal or indulge in any form of criminal behavior, because his energies are finding outlet through other channels.

Now, in our urban population, the mental defective is more often idle and without honest means of livelihood than is the person of normal intelligence, and the reasons for this are not hard to find. In the first place, the home, the neighborhood, and the school have all combined to make him lazy and shiftless and to develop in him a distaste for useful employment. Then, added to the handicap of his unwholesome habits, there is the fact that the only jobs he can obtain are unskilled laboring jobs and a large proportion of these are temporary jobs affording only brief periods of employment.

When, as happens at frequent intervals, the mental defective is given his pay envelope and told that his services are no longer required, what is he likely to do? Will he start off immediately in search of another job? Occasionally, perhaps; but in the majority of cases, having money in his pocket, he will be tempted to lay off for a while, and so there will follow a period of loafing on street corners, in pool rooms, and in other resorts where people of his class tend to congre-

gate. Here his pay is soon spent, and having no money and no job, he is presently tempted to commit some crime—petty larceny, perhaps, or burglary, or even robbery with a gun. If he succeeds in his first crime, he is likely to go on to a second; and if this succeeds, to a third; until, sooner or later, he falls into the hands of the police and is sentenced to prison or penitentiary.

So much for the city-bred mental defective: now for his country cousin. He, like the urban defective, will perhaps be brought up under bad home conditions, and his schooling also will be unfitted to his needs. He will, however, be much more fortunate than the urban defective in the matter of neighborhood conditions. He will not be brought up in a slum amongst criminal associates, because in the country there are no slums. In rural communities, the children of all classes tend to mix, and the mentally defective child as a rule grows up under pretty much the same neighborhood conditions as does the child of normal intelligence.

And as the rural defective is more fortunate in the matter of neighborhood conditions, so also is he more fortunate in the matter of employment: In a rural community there is plenty of work which even a feebleminded child can do, so that his services are generally in demand. When the rural defective absents himself from school, it is not to hang about furtively on street corners, but in all probability to pick fruit, pull weeds, or tend cattle for some farmer in the neighborhood. And later on, when he arrives at man's estate, he does not have much difficulty in securing steady employment. Farm laborers are always needed and the country-bred moron has the tastes, the training, and as much intelligence as is required for this humble calling. So being kept busily employed in an environment where he does not come in contact with criminals and where his earnings are adequate to his simple needs, he is not exposed to much temptation to steal.

We find, therefore, as might be expected, that we get fewer defective delinquents from the country than from the city, and also that in a relatively large proportion of cases, the crimes that our rural defectives commit are not crimes against property, but crimes against the person. They are crimes that spring from crude animal passions in people of inferior

intelligence and low cultural level—as, for example, drunkenness, incest, rape, arson, murder, or criminal assault.

THE PREVENTION OF DELINQUENCY IN THE MENTAL DEFECTIVE

Having looked at the causes of delinquency in the mental defective, we are now in a position to discuss the question of its prevention. If there were no mental defectives, there would be no defective delinquents; so some will say that the solution of the problem that these cases present is to be found in the sterilization of the unfit. In this conclusion, it seems to me that they are, in the final analysis, very probably right. Sterilization will, I believe, be the ultimate solution of our problem. It will, however, be a long time before we can hope to accomplish much in this direction. In the meantime, the mental defective is with us, a steadily increasing social menace, and the practical problem with which we are faced is, What can we do to prevent him from developing into a criminal?

Most criminal defectives would not show criminal tendencies were it not for the fact that, superimposed upon their inborn defects, they have also the results of bad education or training. They are the products, not only of bad heredity, but of an unwholesome environment, and the environmental factors that may operate to develop criminal tendencies in the mental defective, we have seen, are four in number: (1) the home, (2) the neighborhood, (3) the school, and (4) conditions of employment. Let us look again at these four factors, this time with a view to seeing what can be done to correct them.

First, as to the home. Most of our defective delinquents are the victims of bad home conditions, owing to the fact that their parents were defective before them, or were at any rate people of low intellectual and cultural level. Obviously there is not a great deal we can do to correct the bad home conditions in these cases, for we can neither make over the parents whose mental and moral defects are responsible for the trouble, nor can we depose them and set up other parents in their stead. All we can do for the children of such parents is to take them away from their bad home environment. But if we take the defective child away from his home, what are we to do with him? It is seldom possible to place him in a good

foster home because the kind of people who would make good foster parents are not willing to have him. Who wants to adopt as his own a feebleminded child, the offspring of feebleminded parents? We can, if we like, place him in an institution, but even the best institution is a poor substitute for a home.

So we are faced with the fact that there is no possible way in which we can give the mentally defective child of mentally defective parents a good home environment, and in this fact we have an additional argument for the sterilization of the unfit. It is of paramount importance to the child that, during the early formative years of life, he should have good parental training and a good home. But the only way to give the child a good home is to give him good parents, and the only way to give him good parents is by preventing those who are unfit for parenthood from having children.

Next, as to the neighborhood. The neighborhood conditions chiefly productive of criminality in the mental defective are those afforded by the city slums, and the problem of getting better neighborhood conditions for the mental defective is, therefore, mainly a matter of clearing up these hotbeds of crime. But how is that to be accomplished? The causes responsible for the existence of our city slums are social and economic conditions over which we have little or no control. And the same is true of the unsatisfactory conditions of employment which, as we have seen, are also an etiological factor of some importance in the criminality of the urban delinquent.

So we see that with the home, the neighborhood, and conditions of employment, there is at present little that we can do. These are factors in the environment which are not as yet under social control, and until they are under such control, it is useless to propose making changes in them in any mental-hygiene program that we may plan. There is, however, one other factor in the situation that remains to be considered—namely, the school; and here the situation is quite different. For the school is under social control: it is an institution that, within certain fairly broad limits at least, we can modify in accordance with our social needs. Moreover, the school is not only itself a controlled factor in our social life; it is also an instrument and a force by means of which other social forces may be modified. Let us, therefore, consider the ques-

tion of what changes in our school system would seem necessary or desirable from our mental-hygiene point of view.

The first and most pressing need in our educational system is one that has to do with the nature of the school curriculum. The ordinary public school, we have seen, affects the mental defective unfavorably in two ways. First, it makes demands upon him with which, by reason of his mental limitations, he is unable to comply, and so tends to make him an outlaw, an enemy of constituted authority. Second, it affords him no opportunity for employment suited to his tastes or abilities and so develops in him habits of idleness, with all the attendant evils to which such habits give rise. The cure for this unfortunate state of affairs is, of course, to do away with the old lock-step method of education in which each child is expected to learn exactly the same things and at exactly the same rate of speed. What we need is a more varied and flexible curriculum, so that each individual child may be given a mental diet suited to his own individual requirements. And it is gratifying to observe that there is at the present time a growing recognition of this necessity. The establishment of ungraded and special classes in our public schools is an important step in the right direction. It is, however, only a beginning. We still have a long way to go.

The second great need is for a more adequate recreational program. Every young thing needs to play. It is essential to his physical and mental development, and the evil tendencies that young people develop in the crime-breeding areas of our great cities are for the most part acquired on street corners, in pool rooms, dance halls, and other resorts where they go in search of amusement. It is an essential part of a young person's education to learn to gratify his instinctive demands for play or recreation in the right way. This, however, he cannot be expected to do if the necessary facilities and guidance for so doing are not provided. It is true that the slum is a product of economic forces which we have not yet learned to control, but the slum would lose a large part of its power for evil if, in our system of public education, we gave the problem of recreational guidance the serious attention that it deserves.

A third need which may be mentioned—although it is one that is already receiving a good deal of attention—is the need

for a psychiatric service in the public schools to take care of special problem cases. A great many of those who later become inmates of our penal institutions begin as behavior problems in the school. These cases should be made the subject of special scientific study and care. They should not be allowed to go on, as they have in the past, until their criminal tendencies have had time to develop and become fixed.

And fourth and lastly, there is the need in our public-school system for a department of vocational guidance. The transition from the schoolroom to the world of industry and business is a dangerous and difficult one which the youngster should not be left to make unaided. There is danger under our present hit-or-miss methods that he will fail to find the right kind of a job and so will become a misfit and a failure. There is even danger that he will not settle down to any job at all, but will become an idler and a drifter. This, we have seen, is particularly liable to occur in the case of the mental defective, and in this fact we have one of the principal reasons why he so frequently finds his way into delinquency and crime.

Although we cannot make over the conditions of employment in conformity with the needs of the individual, we can help the individual to find the job in which he will be most likely to get along; and as showing what may be done in the way of successfully placing misfits in industry, I should like to call attention to the valuable and interesting pioneer work of the Vocational Adjustment Bureau for Girls, in New York City, the founder and moving spirit of which is Mrs. Henry Ittleson, and the scientific director, Dr. Emily T. Burr.

CONCLUSION

So the conclusion to which we come is that, under existing conditions at least, the problem of the defective delinquent is to be looked upon as being mainly a problem in pedagogy. Treatment of these cases in our penal institutions is essentially a matter of reëducation. But reëducating grown men and women whose evil tendencies have become fixed with the years is by no means a simple or an easy matter. It would have been much simpler, easier, and less expensive, as well as pleasanter for all concerned, to have educated them properly in the first place.

And what is true of our defective delinquents is true of

criminals generally, and of practically all the misfits and failures with which psychiatry attempts to deal. If crime and mental disease are to be prevented, if we are to make any real progress in mental hygiene, it must be as a result of better education along mental-health lines. To-day we see the psychiatrist coming to the aid of the educator, helping him in the handling of his behavior problems in school and college. Before we can hope to make much progress, however, this situation must be reversed: we must have the teacher coming to the aid of the psychiatrist, for it is only by means of better education that our mental ills can be prevented.

REACTION TYPES RESEMBLING FUNCTIONAL PSYCHOSES IN CHILDHOOD ON THE BASIS OF AN ORGANIC INFERIORITY OF THE BRAIN*

PAUL SCHILDER, M.D., PH.D.
Clinical Director, Bellevue Psychiatric Hospital

IT is the general opinion that functional psychoses in childhood are of rare occurrence. Manic-depressive psychoses in children are very rarely observed. Schizophrenia has been more often reported as occurring in early childhood. On the other hand, it is very well known that organic brain diseases play a prominent part in childhood. Encephalitis is of very common occurrence in children; not only epidemic encephalitis, but almost every infectious disease may lead to encephalitic processes. Encephalitis after measles and after smallpox inoculation has lately attracted a good deal of attention. Wohlwill has shown that in the newborn destructive processes of encephalomalacic type are common. Congenital encephalitis doubtless exists. In addition, one has to consider that a birth trauma very often provokes more or less severe destruction in the brain, through hemorrhages and contusions.

One might expect that organic lesions of the brain would produce pictures that are fundamentally different from those observed in the functional psychoses. But this is not the case. Even in the adult, as Wagner-Jauregg, Stransky, and Rittershaus have shown, head injuries often lead to pictures that are very similar to manic-depressive pictures. We know very little about the effect of head injuries in children. But it is more than probable that irritability, hyperexcitability, and flightiness may result from early head injuries. One must bear in mind that even the normal child shows trends that we

* A study from the Research Department of Bellevue Psychiatric Hospital. Read at the round-table discussion of the functional psychoses in childhood at the Ninetieth Annual Meeting of the American Psychiatric Association, New York, May 31, 1934.

would call manic in the adult person. There is the hyperactivity, the wandering of attention, the quick change in emotions, that are so characteristic of manic pictures. I have observed with H. Hartmann a post-encephalitic child who did not show the usual type of hyperkinesis observed in post-encephalitic children. The picture corresponded in all details to the picture of mania. Such cases are certainly rare. In the majority of the cases one does not find manic hyperactivity, but restlessness of a more aimless or more destructive type, or, in other words, the picture of hyperkinesis with which we are so familiar as a consequence of epidemic encephalitis.

But hyperkinesis is one of the most common pictures in children. Kramer and Pollnow have tried to describe it as a definite disease, and say that they have found in one of their cases changes in the brain stem that were not of the type of epidemic encephalitis, but of another type of encephalitis. Clinical experience makes it rather doubtful whether hyperkinesis is a specific entity. One not uncommonly sees children with endocrine disturbances who show a similar disturbance in their behavior. Probably any kind of organic or toxic disturbance affecting the central nervous system of the child may lead to hyperkinetic pictures if the disturbance is not too far-going. If the hyperkinesis is not very outspoken, the picture will resemble more and more a manic picture, but certainly has not the same significance as the manic attack of the manic-depressive psychosis. It is, of course, an open question whether this hypothetical organic or toxic disturbance must be localized in order to produce pictures of this kind; or whether a more or less diffuse disturbance will not produce the same picture, which, after all, belongs to the typical reaction types of the infantile brain.

It is well known that mental defectives often show such restlessness. We know very little about the etiology and pathophysiology of feeblemindedness. We should be extremely careful in all cases of children in which there is a low I.Q. before we make the diagnosis of manic-depressive psychosis. In the first of Kasanin's cases the intelligence quotient was 78; in the second, the I.Q. dropped in the course of the disease from 118 to 66. I would venture the hypothesis that in both cases the organic background was responsible for

the mental picture. In another case, there is a history of hereditary syphilis. With the exception of one case, almost all of Kasanin's cases were around the age of fifteen. In discussing one of the cases (Case 5), the author speaks of a reactive depression in a feebleminded individual. Case 9, eleven years old, with hypomanic pictures, showed a borderline intelligence and signs of an old poliomyelitis. Kasanin himself states that he has not observed affective psychosis under the age of ten. I have seen in Vienna a depressive picture in a boy of eight, with continued self-accusation and feelings of guilt. The nature of the case could not be clearly determined.

I do not doubt that affective psychoses occur close to the time of puberty. It is extremely doubtful whether they occur much before that period. If one analyzes adult manic-depressives, one never gets the impression that their childhood difficulties had a similarity to manic-depressive attacks. I come, therefore, to the conclusion that pictures which resemble manic-depressive pictures in childhood generally do not belong to the group of manic-depressive psychoses, but are connected with more or less organic disturbances in the brain, with toxic influences, or with a constitution which is not that of the adult manic-depressive.

An excursion into the general psychology of the child is necessary when we come to a discussion of the question of schizophrenia in childhood. A study of the attitudes of children toward death which I undertook with Dr. David Wechsler led to some conclusions concerning the way in which children think. There is a definite tendency to realistic observation in a matter-of-fact way. They describe exactly what they have observed when a person dies and is buried. Children even make an attempt to differentiate between what they have been told and what they have observed themselves. Six-year-old Edward C. says:

"How should I know that my parents are in heaven? I am not a fortune-teller. I heard somebody say the angel takes the soul, but I am not sure about it. They read it out of the Bible. I did not see it myself. But I am sure they are lying under the ground."

Very often children accept the convention and then become unable to solve the contradiction between the convention and

their own observation. But also they show no tendency to do it. Six-year-old George M. says:

"Dead people go down a big hole and then they put a lot of sand on. They don't feel anything. When we are good we go to heaven. We don't feel nothing up there. The hole that they put the people in is near to heaven, right next to it. If you are bad, you go to hell and burn up. It hurts, but you don't know if you are burnt or not."

In schizophrenia we would call such an attitude double registration. The knowledge that the child has about many topics is dependent upon what it hears by chance. It is, therefore, rather scattered and unreliable. The child generalizes its casual knowledge. There is undue generalization. For one child all diseases are pneumonia, and according to another all human beings die from throat disease. Our children are almost unanimous in stating that they do not want to die, even when they have just declared how nice it is in heaven. At the same time they have no clear idea of what dying means. The word is seemingly for them a shell which contains something agreeable or disagreeable, although its exact content and meaning is not known.

These few remarks are, of course, not intended even as an attempt at a solution of the problem of the child's thinking processes. They merely underline what Wildermuth also has stressed—that schizophrenic thinking and the thinking of the child have many points in common. We may assume that organic diseases or organic deterioration will underline these features. When one takes children with I.Q.'s between 50 and 60, one hardly ever fails to find indications of violent reactions and apparent signs of dissociations that are not clearly understandable. Dr. Bromberg has studied a number of cases in which the individual and family history pointed to an organic deficiency, which presented pictures with a great similarity to that of schizophrenia. The I.Q. in these cases was low. In other cases there was a definite organic hint in the motility. In another group of cases with definite mental deficiency the clear-cut conflict led to primitive symbolizations which corresponded very closely to schizophrenic behavior.

In order to understand cases of this kind, we must remember that when we talk about "mental deficiency," we are using a very inaccurate term. The assumption that the emotions

of the mentally deficient person are normal is one that is disproved by every experience. When we study such cases carefully, we see that the emotions of the mentally deficient person are defective, too. There are flat, inadequate emotions, or sudden and violent outbursts of rage. There is apathy, indifference, lack of impulses, sudden epileptoid changes, and sudden outbursts; in other words, we have organically founded aberrations in the emotional sphere. Conflict situations in life are, therefore, from the beginning conceived in a different way and accompanied by abnormal reactions in the emotional sphere. Since in all these cases the ego system, the emotional control is impaired, the conflicts will have a more lasting effect, since the outbursts will be uninhibited. Incomplete verbal facilities will lead to a frequent use of incompletely understood words (word shells). The vivid function of phantasy, the play instincts, will be increased, and the primitive drives, especially the sadistic ones, will come uninhibited into the foreground.

We have, therefore, four components: (1) there will be the intellectual inferiority and the consequent frequent use of word shells, undue generalizations, and insensitivity to contradictions; (2) there will be an unregulated emotional system which reacts in an inadequate way to every problem; (3) a symptom once created will not be corrected; (4) the primitive drives will come strongly into the foreground.

One sees how great is the similarity of these pictures to that of schizophrenia. The minor degrees of mental deficiency will be particularly apt to provoke such pictures, but mental deficiency and stupidity or dull normality are not so far apart. One should, therefore, be particularly careful about making the diagnosis of schizophrenia in cases with an I.Q. below 80.

Of course, I do not doubt that schizophrenia does occur in childhood. The observations of Potter are particularly persuasive in this respect. But I think that one has to consider carefully the I.Q. and its effect on the emotional life before one makes the diagnosis of schizophrenia in childhood. A very careful neurological examination, with special consideration given to tone and posture, will also be necessary. I may mention that Neustadt has pointed out the fact that there are psychoses in mentally deficient persons which in spite of their

resemblance to schizophrenia are not schizophrenia. These investigations shed a new light also upon the problem of *Propf* schizophrenia, or schizophrenia superimposed upon mental deficiency. Many of such cases will turn out to be mere schizoid reactions in the sense described above. A combination of schizophrenia and mental deficiency may, of course, occur, but, according to my experience, it is extremely rare.

I arrive, therefore, at the conclusion that pictures which resemble schizophrenia in childhood are very often not schizophrenic, but organic; they are schizoid reactions in connection with organic processes and defects of the brain. I assume as a matter of course that dementia precocissima (De Sanctis) and dementia infantilis (Heller) have nothing to do with schizophrenia, but are organic processes. Greene has shown conclusively how common are psychotic manifestations in deficient children. If we consider the general points of view discussed here, we come to a better understanding of these psychoses. There is not the least proof that deteriorating processes which lead to organic signs and mental deficiency in childhood are in any way related to the disease entity of schizophrenia.

I quote a few cases from a paper by Dr. Bromberg:

> Theodore, eleven years old, Stanford-Binet mental age 7 years, 2 months, is fearful, with sudden sadistic outbursts. He says: "I will kill you! I will kill you! I want to take the poop out of his head and make it clean." "I am going to fry him, he will fry all day long till he gets finished." He draws a picture: "He is cooking the boy's head in the pot." "The pot is turned upside down and the head is coming out." Here again the words are used rather in an emotional than in a logical sense.
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> Lawrence L., eight years of age, Stanford-Binet I.Q. 81, says in a playful way: "I am a rabbit. You are a snake. I'll throw you out of the window." "Why?" "Because you have big pants." He says to the examiner: "You pancake, I'll cook you in the oven." Besides this primitive identification of human beings with animals and inanimate objects, there are open outbreaks of sadistic actions against other children and against the examiner. He uses the words as shells; the emotional content and the direction of striving expressed in them is more important than their logical meaning.
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> In another of Bromberg's cases, a clear-cut case of mental defect, the boy was often found standing at a window waving a handkerchief and saying, "I surrender." He had taken this word and the situation from a book, but his whole attitude was a masochistic one. Indeed, he

was always ready to surrender. The word "surrender" is again a word shell for an important instinctual drive.

In the case of a twenty-three-year-old boy with an I.Q. (Stanford-Binet test) of 68 on the 16-year level and 72 on the 15-year level, overcareful training had given him verbal facilities beyond his intelligence. This again led to the use of words rather in an instinctual than in an intelligent way: "I think it is a lack of control. You sort of can't control your emotions. You don't know how. You sort of can't control yourself and have to go to people for help." Behind his utterances were severe self-reproaches concerning masturbation and degeneracy. He wanted to be sterilized. Unable to cope with his instinctual drives, he got into a long-lasting state of excitement and restlessness.

I come, therefore, to the following conclusion: The emotional patterns of a child have in themselves a similarity to manic pictures. The incompleteness of his intellectual apparatus in connection with strong drives, in thinking as well as in action, will lead to results which are in many respects similar to the results of schizophrenic thinking. Inferiority of the brain, acquired or constitutional, will lead to an increase in the emotional and intellectual peculiarities in a child's behavior, and pictures of psychoses will occur that are similar to those of schizophrenia and mania although they are not identical with these disease entities. Every organic inferiority of the brain also will have an immediate influence on the repressive forces. Primitive drives and emotions, as well as primitive motor tendencies, will, therefore, come out in a much more open way. In addition, the reaction to conflicts will be less controlled, more deep-lying, and longer lasting. Pictures resembling functional psychosis in childhood will therefore very often not be the disease entity, manic-depressive psychosis or schizophrenia, but the reaction of a psycho-physiological organization that is undeveloped and that suffers from a weakness in the ego system. Or, in the language of physiology, these pictures are reaction types of an undeveloped and pathologically inferior brain organization.

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THINKING AND PRACTICE IN FORENSIC PSYCHIATRY*

C. B. HORTON, M.D.
Director, Bureau of Mental Hygiene, State Department of Health, Hartford, Connecticut

IN an article entitled *The Criminal Insane Under Jurisdiction,* in MENTAL HYGIENE for July, 1934, Dr. Rudolph Schwarz, of the Dannemora State Hospital, calls attention to a pathetic group of persons convicted of crime in spite of ample evidence of gross mental disease. The inadequacies of present-day law in dealing with conditions involving disordered mentality are painfully apparent to many leaders of juridical thought as well as to forensic psychiatrists, and Dr. Schwarz does well to present a list of cases illustrating the results of some of these legal inadequacies. A similar list was reported in 1932 to the Section of Criminal Laws and Criminology of the American Bar Association by its own Committee on Psychiatric Jurisprudence. Professor Weihofen's recent book, *Insanity as a Defense in Criminal Law,* which was reviewed in the April, 1934, issue of MENTAL HYGIENE, discusses the very unsatisfactory state of present laws on this subject. It is well known that psychiatric jurisprudence is in a very unsettled state and will probably remain so for some time, but it is cheering to realize that the Bar Association is aware of the problem and is moving to deal with it.

Forensic psychiatrists and orthopsychiatrists are faced with problems of the law as it exists to-day and cannot neglect to adapt their practice to this reality situation. At the same time it does not seem necessary to allow their thinking to be restricted by outworn concepts of law which are troubling even the lawyers. It was apparently this discrepancy between forensic practice and psychiatric thinking that caused Dr. Schwarz to open his article with the following surprising paragraph:

* EDITOR'S NOTE: An interesting discussion of this question, presenting both the legal and the psychiatric points of view, was held at a joint meeting of the New York Neurological Society and the New York Academy of Medicine, Section of Neurology and Psychiatry, on November 13, 1934. It is published under the title "Psychiatry and the Criminal Law," in the *Journal of Nervous and Mental Disease,* Vol. 81, pp. 192–212, February, 1935.

> "The question of insanity before the court has always been of great importance, and lately has aroused great interest in professional circles and in the public in general. Attempts to define 'the criminal' have been rather unsatisfactory. The question of guilt has had a tendency to assume a philosophical shading, and we have to avoid this tendency to remain practical and helpful for the law. Such a philosophy would claim that we are only the product of heredity and environment and, therefore, not responsible for what we are doing. It would classify each criminal as a sick person and all our mistakes as the outcome of natural phenomena. This theory appears to be unworkable, and we do better to adhere to the old standard of 'right and wrong.' This means that a criminal is a man who knows right and does wrong. On the other hand, a criminally insane person does not know right and consequently does wrong."

While fully sympathizing with Dr. Schwarz's difficulty in trying to reconcile his psychiatric point of view with the demands of contemporary legal practice, it still must be objected that this paragraph constitutes a complete recantation of the mental-hygiene concept of crime and delinquency. The advice "to adhere to the old standard of 'right and wrong' " has long since been rejected by scientific psychiatry, which attempts to think in terms of cause and effect and to withhold moral judgments as irrelevant to its purpose. The proffered definitions of a "criminal" and of a "criminally insane person" are psychiatrically untenable. One of Dr. Schwarz's own cases, No. 2121, describes a patient who "knew right and did wrong," yet was unquestionably reacting to his psychotic hallucinations while doing the "wrong." Even the court in New Hampshire has ruled that if the defendant had a mental disease, and if the criminal act was the product of that mental disease, he should be acquitted.

But most disturbing of all is Dr. Schwarz's rejection of the factors of heredity and environment in producing crime. The science and art of orthopsychiatry is built up on the conviction that we are "the product of heredity and environment," and that "our mistakes" are "the outcome of natural phenomena." This theory, which to Dr. Schwarz "appears to be unworkable," is very important to our present thinking and in fact would seem indispensable to mental hygiene. If "to remain practical and helpful for the law" should mean to jettison entirely our modern psychiatric concept of behavior, then we should by all means remain impractical and leave the law to its fate. Fortunately, these alternatives are not the only courses open to us.

A STATISTICAL STUDY OF AGE IN RELATION TO MENTAL DISEASE

BENJAMIN MALZBERG

New York State Department of Mental Hygiene

THE following analysis of age as a factor in mental disease is based upon first admissions to all institutions for mental disease in the state of New York during the three fiscal years ended June 30, 1931. The probability of a mental disorder is not the same at all ages, nor in the several psychoses. In this study, therefore, an attempt is made to draw a detailed picture of these differences. It is true, of course, that age at first admission is not synonymous with age at onset of the disease, and that there is sometimes a considerable lag between the two. But for purposes of objective study, it is necessary to work with data pertaining to age at first admission, since age at onset cannot be clearly specified, and is seldom reported with a degree of accuracy that justifies detailed analysis.

During the three years ended June 30, 1931, there were 28,689 first admissions to institutions for mental disease in New York State. Of these 15,992, or 55.7 per cent, were males, and 12,697, or 44.3 per cent, females. The classification of these first admissions according to psychoses is shown in Table 1 (page 2).

Dementia praecox includes 7,539 first admissions, or 26.3 per cent of the total. Psychoses with cerebral arteriosclerosis and manic-depressive psychoses follow, each including 13.4 per cent of all first admissions. General paralysis, senile psychoses, and alcoholic psychoses represent 9.9, 8.8 and 6.1 per cent, respectively.

Among male first admissions, dementia praecox is the leading category, with 26.0 per cent of the total. General paralysis is next, with 14.1 per cent, followed by psychoses with cerebral arteriosclerosis, with 13.7 per cent. The manic-depressive psychoses rank fourth with 9.6 per cent, the

alcoholic psychoses following closely with 9.2 per cent. The senile psychoses include 6.6 per cent.

Among female first admissions, dementia praecox, with 26.6 per cent, is again the leading category. The manic-depressive psychoses include 18.2 per cent, a marked increase over the male percentage. Psychoses with cerebral arterio-

TABLE 1.—FIRST ADMISSIONS TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931

Psychoses	*Males*		*Females*		*Total*	
	Number	Per cent	Number	Per cent	Number	Per cent
Traumatic	243	1.5	35	0.3	278	1.0
Senile	1,050	6.6	1,464	11.5	2,514	8.8
With cerebral arteriosclerosis	2,193	13.7	1,668	13.1	3,861	13.4
General paralysis	2,255	14.1	587	4.6	2,842	9.9
With cerebral syphilis	213	1.3	92	0.7	305	1.1
With Huntington's chorea	22	0.1	22	0.2	44	0.2
With brain tumor	31	0.2	15	0.1	46	0.2
With other brain or nervous diseases	230	1.4	147	1.2	377	1.3
Alcoholic	1,474	9.2	287	2.3	1,761	6.1
Due to drugs and other exogenous toxins	46	0.3	49	0.4	95	0.3
With pellagra	1	*	5	*	6	*
With other somatic diseases	224	1.4	393	3.1	617	2.2
Manic-depressive	1,530	9.6	2,316	18.2	3,846	13.4
Involution melancholia	274	1.7	536	4.2	810	2.8
Dementia praecox	4,163	26.0	3,376	26.6	7,539	26.3
Paranoia or paranoic conditions	131	0.8	156	1.2	287	1.0
Epileptic psychoses	306	1.9	233	1.8	539	1.9
Psychoneuroses and neuroses	190	1.2	308	2.4	498	1.7
With psychopathic personality	453	2.8	302	2.4	755	2.6
With mental deficiency	428	2.7	343	2.7	771	2.7
Undiagnosed psychoses	296	1.9	241	1.9	537	1.9
Without psychosis	239	1.5	122	1.0	361	1.3
Total	15,992	100.0	12,697	100.0	28,689	100.0

* Less than 0.05 per cent.

sclerosis and the senile psychoses follow with 13.1 and 11.5 per cent, respectively.

Summary comparisons of the age distribution of the first admissions in the several groups of psychoses are shown in Table 2.

The average age at time of first admission is 45.5 years. During the fiscal years 1919 to 1921, the average age of first admissions was 43.6 years. In a decade, therefore, the average age increased by almost two years. Most of the important groups of psychoses show similar increases in average

TABLE 2.—AVERAGE AGES OF FIRST ADMISSIONS TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, TOGETHER WITH STANDARD DEVIATIONS, CLASSIFIED ACCORDING TO PSYCHOSES

Psychoses	Average age (years)			Standard deviation (years)		
	Males	Females	Total	Males	Females	Total
Traumatic	48.1±0.6	49.9±1.7	48.3±0.6	14.9±0.4	14.8±1.2	14.8±0.4
Senile	74.1±0.2	74.7±0.1	74.5±0.1	7.6±0.1	8.3±0.1	9.5±0.1
With cerebral arteriosclerosis	66.8±0.1	65.7±0.2	66.3±0.1	9.3±0.1	10.2±0.1	9.7±0.1
General paralysis	44.7±0.1	43.0±0.3	44.4±0.1	10.3±0.1	11.2±0.2	10.5±0.1
With cerebral syphilis	47.0±0.6	45.2±0.9	46.4±0.5	12.6±0.4	13.5±0.6	12.9±0.4
With Huntington's chorea	51.6±1.5	46.0±1.8	48.9±1.2	10.3±1.1	12.7±1.3	11.8±0.8
With brain tumor	43.0±1.2	46.2±1.6	44.1±1.0	10.3±0.8	9.0±1.1	10.0±0.7
With other brain or nervous diseases	34.3±0.6	34.2±0.8	34.3±0.5	14.3±0.4	14.7±0.6	14.4±0.4
Alcoholic	45.4±0.2	44.3±0.4	45.2±0.2	10.9±0.1	10.0±0.3	10.7±0.1
Due to drugs and other exogenous toxins	44.4±1.3	42.7±1.0	43.6±0.8	12.7±0.9	10.6±0.7	11.7±0.6
With pellagra	*	*	*	*	*	*
With other somatic diseases	48.9±0.7	40.5±0.5	43.6±0.4	14.5±0.5	14.2±0.4	14.9±0.3
Manic-depressive	38.3±0.2	36.2±0.2	37.0±0.1	13.7±0.1	12.4±0.1	13.0±0.1
Involution melancholia	54.9±0.3	52.1±0.2	53.0±0.2	6.9±0.2	7.0±0.1	7.1±0.1
Dementia praecox	31.8±0.1	36.5±0.1	33.9±0.1	10.5±0.1	11.6±0.1	11.2±0.1
Paranoia or paranoic conditions	50.1±0.7	50.5±0.6	50.3±0.5	11.8±0.5	11.8±0.4	11.8±0.4
Epileptic psychoses	35.3±0.5	35.9±0.6	35.6±0.4	13.5±0.4	12.8±0.4	13.2±0.3
Psychoneuroses and neuroses	35.6±0.5	36.7±0.5	36.3±0.4	11.0±0.4	12.2±0.4	11.8±0.3
With psychopathic personality	35.1±0.4	34.8±0.5	35.0±0.3	13.6±0.3	13.2±0.4	13.4±0.2
With mental deficiency	33.3±0.4	34.1±0.5	33.6±0.3	13.2±0.3	12.4±0.4	12.9±0.2
Undiagnosed psychoses	43.6±0.6	39.7±0.6	41.8±0.4	14.7±0.4	13.5±0.4	14.3±0.3
Without psychosis	34.4±0.7	34.2±1.0	34.3±0.6	17.4±0.5	17.1±0.4	17.3±0.4
Total	44.9±0.1	46.1±0.1	45.5±0.1	17.6±0.1	18.3±0.1	17.5±0.1

* Not calculated because of small base.

age at time of first admission, but the general increase is due primarily to the great relative growth during the decade of patients with psychoses with cerebral arteriosclerosis. In 1920 this group represented 4.9 per cent of the total first admissions to the New York civil state hospitals, but during the ensuing decade the percentage increased steadily until in 1930 it had reached 10.3 per cent. During this period the average age of first admission with psychoses with cerebral arteriosclerosis advanced from 65.7 to 66.3 years. The increasing numerical importance of this group, therefore, accounts in very large part for the general increase in the average age at first admission.

During the three fiscal years 1929 to 1931, first admissions with senile psychoses show the highest average age—74.5 years. This is followed by an average of 66.3 years in psychoses with cerebral arteriosclerosis. Involution melancholia and paranoia are also above the general average, with 53.0 and 50.3 years, respectively. General paralysis and the alcoholic psychoses characterize the middle period of life, with averages of 44.4 and 45.2 years, respectively. The lowest average, 33.6 years, occurs in psychoses with mental deficiency. In dementia praecox there is an average of 33.9 years. Other groups with low average ages are psychoses with other brain or nervous diseases (34.3 years), manic-depressive psychoses (37.0), epileptic psychoses (35.6), psychoneuroses and neuroses (36.3), and psychoses with psychopathic personality (35.0).

The male first admissions have an average age of 44.9 years, significantly less than that of the females. The maximum ages occur in the senile psychoses and those with cerebral arteriosclerosis, with averages of 74.1 and 66.8 years, respectively. The minimum average age, 31.8, occurs in dementia praecox. Psychoses with mental deficiency are also low, with an average age of 33.3 years.

Among females the average age is 46.1 years, with a maximum of 74.7 years in the senile psychoses, and a minimum of 34.1 years in psychoses with mental deficiency.

The degree of variation in age differs from one group of psychoses to another. Those with high average ages have the smallest variations. As measured by the standard devia-

tion, the least variation occurs in involution melancholia, the standard deviation being 7.1 years. This low variation is due primarily to the age limitations associated with the involution period. Psychoses with cerebral arteriosclerosis and senile psychoses follow, with standard deviations of 9.7 and 9.5 years, respectively. Excluding those without psychosis, the highest standard deviation, 14.9 years, occurs in psychoses with other somatic diseases. Traumatic psychoses, psychoses with other brain or nervous diseases, psychoses with psychopathic personality, psychoses with epilepsy, and manic-depressive psychoses also show relatively high standard deviations.

A better measure of variation, however, is the coefficient of variation, which expresses the ratio of the standard deviation to the mean. All patients show a variation of 38.5 per cent. The maximum, 50.4 per cent, occurs in the group without psychosis. Excluding this group, we find the highest variation in psychoses with other brain or nervous diseases (42.0), psychoses with mental deficiency (38.4), psychoses with psychopathic personality (38.3), and epileptic psychoses (37.1). The lowest degree of variation occurs in the senile psychoses (12.8), followed by involution melancholia (13.4) and psychoses with cerebral arteriosclerosis (14.6).

There thus appear to be characteristic groupings of the psychoses with respect to age. In the youngest age intervals will be found dementia praecox, psychoses with mental deficiency, and epileptic psychoses. These are succeeded by the manic-depressive psychoses. In middle life the alcoholic psychoses and general paralysis predominate. These are followed by paranoia and involution melancholia. In the oldest age intervals one finds psychoses with cerebral arteriosclerosis and senile psychoses.

This distribution is considered in greater detail in the following sections, in which the life span is divided into broad age intervals. As one passes from the youngest to the oldest age groups, it will be apparent that the psychoses vary in their relative frequencies in characteristic fashion.

Those under 15 years of age do not constitute a large group numerically, but it is interesting to consider the distribution of the psychoses in childhood. Patients in this age group

have been growing in relative frequency for several decades.[1] As shown in Table 3, three diagnostic classifications assume prominence in this age group. The leading classification, constituting 29.6 per cent of the total, is described as without psychosis, and consists largely of children with behavior disorders. The growth in this group is undoubtedly a reflection of the interest in behavior problems among children stimulated by the child-guidance movement. The next group consists of psychoses with other brain or nervous diseases, which includes 16.2 per cent of the total. This group consists in large part of cases of encephalitis lethargica, a disease that has assumed significance since 1920. The third largest group, making up 15.6 per cent of the whole, is that of dementia praecox. Psychoses with psychopathic personality, psychoses with mental deficiency, and manic-depressive psychoses follow in the order named, with 9.5, 6.7, and 5.6 per cent, respectively. There are no important sex differences in this group.

The distribution in the group aged 15 to 24 years, which is shown in Table 4, differs from the preceding. Dementia praecox includes almost half the first admissions in this age group (49.5 per cent). The manic-depressive psychoses follow with 22.0 per cent. Compared with these, no other group of psychoses is of numerical significance. There are important sex differences. Dementia praecox includes 57.5 per cent of the males in this age group, but only 38.2 per cent of the females. The manic-depressive psychoses, on the other hand, include 31.8 per cent of the females, and only 15.1 per cent of the males. Compared to the general population aged 15 to 24 years, there is a marked difference among males, there being 38.7 first admissions with dementia praecox per 100,000 population, and a rate of only 10.2 with manic-depressive psychoses. Among the females, however, the difference in the rates was much less, these being 17.3 and 14.4 for dementia praecox and manic-depressive psychoses, respectively.

In the age group 25 to 34 years, dementia praecox and the manic-depressive psychoses are again the outstanding

[1] For a detailed study of these changes see "A Statistical Study of the Prevalence and Types of Mental Disease Among Children and Adolescents" by Benjamin Malzberg. *Psychiatric Quarterly*, Vol. 5, pp. 511–37, July, 1931.

TABLE 3.—FIRST ADMISSIONS, UNDER 15 YEARS OF AGE, TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, CLASSIFIED ACCORDING TO PSYCHOSES

Psychoses	*Total first admissions*			*Per cent of all admissions*			*Rate per 100,000 population*		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Traumatic	3	..	3	2.8	....	1.7	0.1	...	*
Senile	..	..	..	....	....	....	...	...	...
With cerebral arteriosclerosis	..	..	..	....	....	....	...	...	...
General paralysis	5	2	7	4.6	2.8	3.9	0.1	*	0.1
With cerebral syphilis	..	1	1	....	1.4	0.6	...	*	*
With Huntington's chorea	..	..	..	....	....	....	...	...	...
With brain tumor	..	..	..	....	....	....	...	...	...
With other brain or nervous diseases	19	10	29	17.6	14.1	16.2	0.4	0.2	0.3
Alcoholic	..	..	..	....	....	....	...	...	...
Due to drugs and other exogenous toxins	..	..	..	....	....	....	...	...	...
With pellagra	..	..	..	....	....	....	...	...	...
With other somatic diseases	1	1	2	0.9	1.4	1.1	*	*	*
Manic-depressive	5	5	10	4.6	7.0	5.6	0.1	0.1	0.1
Involution melancholia	..	..	..	....	....	....	...	...	...
Dementia praecox	16	12	28	14.8	16.9	15.6	0.3	0.3	0.3
Paranoia or paranoic conditions	..	..	..	....	....	....	...	...	...
Epileptic psychoses	5	3	8	4.6	4.2	4.5	0.1	0.1	0.1
Psychoneuroses and neuroses	1	5	6	0.9	7.0	3.4	*	0.1	0.1
With psychopathic personality	11	6	17	10.2	8.5	9.5	0.2	0.1	0.2
With mental deficiency	7	5	12	6.5	7.0	6.7	0.2	0.1	0.1
Undiagnosed psychoses	1	2	3	0.9	2.8	1.7	*	*	*
Without psychosis	34	19	53	31.5	26.8	29.6	0.7	0.4	0.6
Total	108	71	179	100.0	100.0	100.0	2.3	1.5	1.9

* Less than 0.05 per 100,000 population.

TABLE 4.—FIRST ADMISSIONS, 15 TO 24 YEARS OF AGE, TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, CLASSIFIED ACCORDING TO PSYCHOSES

Psychoses	*Total first admissions*			*Per cent of all admissions*			*Rate per 100,000 population*		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Traumatic	16	2	18	0.7	0.1	0.5	0.5	0.1	0.3
Senile	....	...	....	....	....	....	....	....	....
With cerebral arteriosclerosis	....	...	....	....	....	....	....	....	....
General paralysis	28	21	49	1.3	1.4	1.3	0.9	0.6	0.7
With cerebral syphilis	6	4	10	0.3	0.3	0.3	0.2	0.1	0.2
With Huntington's chorea	....	1	1	....	0.1	*	....	†	†
With brain tumor	1	...	1	0.1	....	*	†	....	†
With other brain or nervous diseases	47	41	88	2.2	2.7	2.4	1.5	1.2	1.3
Alcoholic	24	8	32	1.1	0.5	0.9	0.7	0.2	0.5
Due to drugs and other exogenous toxins	1	...	1	0.1	....	*	†	....	†
With pellagra	....	1	1	....	0.1	*	....	†	†
With other somatic diseases	15	59	74	0.7	3.9	2.0	0.5	1.8	1.1
Manic-depressive	328	486	814	15.1	31.8	22.0	10.2	14.4	12.3
Involution melancholia	....	...	....	....	....	....	....	....	....
Dementia praecox	1,250	583	1,833	57.5	38.2	49.5	38.7	17.3	27.8
Paranoia or paranoic conditions	....	1	1	....	0.1	*	....	†	†
Epileptic psychoses	76	45	121	3.5	3.0	3.3	2.4	1.3	1.8
Psychoneuroses and neuroses	36	50	86	1.7	3.3	2.3	1.1	1.5	1.3
With psychopathic personality	110	83	193	5.1	5.4	5.2	3.4	2.5	2.9
With mental deficiency	146	89	235	6.7	5.8	6.4	4.5	2.6	3.6
Undiagnosed psychoses	34	37	71	1.6	2.4	1.9	1.1	1.1	1.1
Without psychosis	55	17	72	2.5	1.1	2.0	1.7	0.5	1.1
Total	2,173	1,528	3,701	100.0	100.0	100.0	67.3	45.3	56.1

* Less than 0.05 per cent.
† Less than 0.05 per 100,000 population.

groups. (See Table 5.) They include 45.8 and 18.6 per cent, respectively, of the total first admissions. General paralysis and the alcoholic psychoses begin to present significant totals, the former including 8.0 per cent, the latter 5.1 per cent. These two disorders are restricted largely to males. In general paralysis the first admission rates are 10.1 and 3.2 per 100,000 population for males and females, respectively. In the alcoholic psychoses, the corresponding rates are 7.3 and 1.2, respectively. Dementia praecox, though including fewer of the total first admissions in this age group, has a higher annual rate of first admissions. The rate increases to 44.4 per 100,000 population among males, and to 31.1 among females. The manic-depressive psychoses also show an increase in the annual rate, especially among females. Among the latter the rate has grown from 14.4 at 15 to 24 years to 20.4 at 25 to 34 years.

In the age group 35 to 44 years, as shown in Table 6, dementia praecox is again the leading group, but it includes only 31.6 per cent of the total first admissions, as compared with 45.8 per cent in the preceding age group. General paralysis has advanced to second place, including 18.0 per cent of the total. The manic-depressive psychoses follow with 16.0 per cent. The alcoholic psychoses represent 9.9 per cent of the total.

The sex differences are marked. Among the males, dementia praecox is the largest single group, with 27.5 per cent of the total, followed closely by general paralysis with 25.4 per cent. The alcoholic psychoses exceed the manic-depressive psychoses, the respective percentages being 14.3 and 10.9. Among the females, on the other hand, dementia praecox represents over a third of the total (36.8). The manic-depressive psychoses follow with 22.5 per cent. General paralysis and the alcoholic psychoses are far behind, with 8.5 and 4.2 per cent, respectively.

On the basis of rates per 100,000 population, dementia praecox shows a marked decline among males from 44.4 at 25 to 34 years to 30.6 at 35 to 44 years, but the female rate has increased from 31.1 to 33.9. In the manic-depressive psychoses both sexes show slightly higher rates. The increases are marked in general paralysis, the rates growing from 10.1

TABLE 5.—FIRST ADMISSIONS, 25 TO 34 YEARS OF AGE, TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, CLASSIFIED ACCORDING TO PSYCHOSES

Psychoses	*Total first admissions*			*Per cent of all admissions*			*Rate per 100,000 population*		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Traumatic	33	3	36	1.1	0.1	0.7	1.0	0.1	0.6
Senile	1	....	1	*	....	*	†	....	†
With cerebral arteriosclerosis	1	....	1	*	....	*	†	....	†
General paralysis	330	107	437	11.1	4.4	8.0	10.1	3.2	6.6
With cerebral syphilis	35	18	53	1.2	0.7	1.0	1.1	0.5	0.8
With Huntington's chorea	2	2	4	0.1	0.1	0.1	0.1	0.1	0.1
With brain tumor	5	2	7	0.2	0.1	0.1	0.2	0.1	0.1
With other brain or nervous diseases	53	34	87	1.8	1.4	1.6	1.6	1.0	1.3
Alcoholic	239	40	279	8.0	1.6	5.1	7.3	1.2	4.2
Due to drugs and other exogenous toxins	9	12	21	0.3	0.5	0.4	0.3	0.4	0.3
With pellagra	....	1	1	....	*	*	....	†	†
With other somatic diseases	24	90	114	0.8	3.7	2.1	0.7	2.7	1.7
Manic-depressive	337	676	1,013	11.3	27.6	18.6	10.3	20.4	15.4
Involution melancholia	....	1	1	....	*	*	....	†	†
Dementia praecox	1,456	1,031	2,487	48.8	42.1	45.8	44.4	31.1	37.8
Paranoia or paranoic conditions	15	14	29	0.5	0.6	0.5	0.5	0.4	0.4
Epileptic psychoses	79	76	155	2.7	3.1	2.9	2.4	2.3	2.4
Psychoneuroses and neuroses	52	96	148	1.7	3.9	2.7	1.6	2.9	2.3
With psychopathic personality	132	67	199	4.4	2.7	3.7	4.0	2.0	3.0
With mental deficiency	96	97	193	3.2	4.0	3.6	2.9	2.9	2.9
Undiagnosed psychoses	53	52	105	1.8	2.1	1.9	1.6	1.6	1.6
Without psychosis	31	33	64	1.0	1.4	1.2	1.0	1.0	1.0
Total	2,983	2,452	5,435	100.0	100.0	100.0	91.1	74.1	82.5

* Less than 0.05 per cent.
† Less than 0.05 per 100,000 population.

TABLE 6.—FIRST ADMISSIONS, 35 TO 44 YEARS OF AGE, TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, CLASSIFIED ACCORDING TO PSYCHOSES

Psychoses	*Total first admissions*			*Per cent of all admissions*			*Rate per 100,000 population*		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Traumatic	39	6	45	1.1	0.2	0.7	1.3	0.2	0.8
Senile	1	...	1	*	....	*	†	....	†
With cerebral arteriosclerosis	23	39	62	0.7	1.5	1.0	0.8	1.4	1.0
General paralysis	866	225	1,091	25.4	8.5	18.0	28.2	7.8	18.3
With cerebral syphilis	49	22	71	1.4	0.8	1.2	1.6	0.8	1.2
With Huntington's chorea	4	8	12	0.1	0.3	0.2	0.1	0.3	0.2
With brain tumor	8	5	13	0.2	0.2	0.2	0.3	0.2	0.2
With other brain or nervous diseases	63	28	91	1.9	1.1	1.5	2.1	1.0	1.5
Alcoholic	488	112	600	14.3	4.2	9.9	15.9	3.9	10.1
Due to drugs and other exogenous toxins	18	19	37	0.5	0.7	0.6	0.6	0.7	0.6
With pellagra	1	...	1	*	....	*	†	....	†
With other somatic diseases	41	95	136	1.2	3.6	2.2	1.3	3.3	2.3
Manic-depressive	373	598	971	10.9	22.5	16.0	12.1	20.7	16.3
Involution melancholia	18	90	108	0.5	3.4	1.8	0.6	3.1	1.8
Dementia praecox	940	977	1,917	27.5	36.8	31.6	30.6	33.9	32.2
Paranoia or paranoic conditions	28	39	67	0.8	1.5	1.1	0.9	1.4	1.1
Epileptic psychoses	78	58	136	2.3	2.2	2.2	2.5	2.0	2.3
Psychoneuroses and neuroses	66	77	143	1.9	2.9	2.4	2.2	2.7	2.4
With psychopathic personality	92	79	171	2.7	3.0	2.8	3.0	2.7	2.9
With mental deficiency	85	83	168	2.5	3.1	2.8	2.8	2.9	2.8
Undiagnosed psychoses	81	72	153	2.4	2.7	2.5	2.6	2.5	2.6
Without psychosis	52	22	74	1.5	0.8	1.2	1.7	0.8	1.2
Total	3,414	2,654	6,068	100.0	100.0	100.0	111.1	92.0	101.8

* Less than 0.05 per cent.
† Less than 0.05 per 100,000 population.

to 28.2 among males and from 3.2 to 7.8 among females. In the alcoholic psychoses, the rates have grown from 7.3 to 15.9 among males and from 1.2 to 3.9 among females.

In the age interval 45 to 54 years, dementia praecox, general paralysis, manic-depressive psychoses, and alcoholic psychoses are, as shown in Table 7, the leading groups of psychoses, in the order named. Compared with the preceding age interval, there is a marked reduction, however, in dementia praecox, which includes only 19.3 per cent of the first admissions instead of 31.6, and shows a rate of 21.6 per 100,000 population instead of 32.2. This decrease is counterbalanced by increases in psychoses with cerebral arteriosclerosis and involution melancholia. The former include 8.5 per cent of the first admissions, the latter 8.2 per cent, and they have rates of 9.5 and 9.1 per 100,000 population, respectively, compared with corresponding rates of 1.0 and 1.8 in the preceding age interval.

The sex differences are marked. Among males, general paralysis is the leading category, growing from a rate of 28.2 to 30.4. The alcoholic psychoses follow with a rate of 19.5, compared with 15.9 in the preceding age interval. Dementia praecox is third, its rate having decreased from 30.6 to 17.4. The manic-depressive psychoses, which follow, show a slight increase. Among females, dementia praecox leads with a rate of 26.0, a decrease from the preceding rate of 33.9. The manic-depressive psychoses are second, though the rate has fallen from 20.7 to 17.4. Involution melancholia ranks third, with a rate of 13.1, a marked increase over the rate in the preceding age interval, which was 3.1.

In the age group 55 to 64 years, further characteristic changes appear in the distribution of the psychoses, as shown in Table 8. Dementia praecox and the manic-depressive psychoses have decreased markedly. General paralysis and the alcoholic psychoses have also decreased, the former showing a sharp decline from a rate of 19.0 to 12.7. The alcoholic psychoses show a smaller rate of decline. Involution melancholia shows a slight increase, due to a growth in the male rate. Marked increases occur in the senile psychoses and in psychoses with cerebral arteriosclerosis. The former include 7.7 per cent of the first admissions in this age group, and

TABLE 7.—FIRST ADMISSIONS, 45 TO 54 YEARS OF AGE, TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, CLASSIFIED ACCORDING TO PSYCHOSES

Psychoses	*Total first admissions*			*Per cent of all admissions*			*Rate per 100,000 population*		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Traumatic	70	11	81	2.6	0.5	1.7	3.2	0.5	1.9
Senile	7	18	25	0.3	0.9	0.5	0.3	0.9	0.6
With cerebral arteriosclerosis	205	202	407	7.6	9.8	8.5	9.3	9.7	9.5
General paralysis	669	145	814	24.7	7.0	17.0	30.4	7.0	19.0
With cerebral syphilis	73	27	100	2.7	1.3	2.1	3.3	1.3	2.3
With Huntington's chorea	5	3	8	0.2	0.1	0.2	0.2	0.1	0.2
With brain tumor	10	6	16	0.4	0.3	0.3	0.5	0.3	0.4
With other brain or nervous diseases	32	19	51	1.2	0.9	1.1	1.5	0.9	1.2
Alcoholic	429	82	511	15.8	4.0	10.7	19.5	3.9	11.9
Due to drugs and other exogenous toxins	7	9	16	0.3	0.4	0.3	0.3	0.4	0.4
With pellagra	...	1	1	...	0.1	*	...	0.1	†
With other somatic diseases	64	88	152	2.4	4.3	3.2	2.9	4.2	3.6
Manic-depressive	294	363	657	10.9	17.5	13.8	13.4	17.4	15.3
Involution melancholia	118	273	391	4.4	13.2	8.2	5.4	13.1	9.1
Dementia praecox	382	542	924	14.1	26.2	19.3	17.4	26.0	21.6
Paranoia or paranoic conditions	47	49	96	1.7	2.4	2.0	2.1	2.4	2.2
Epileptic psychoses	39	30	69	1.4	1.5	1.4	1.8	1.4	1.6
Psychoneuroses and neuroses	26	56	82	1.0	2.7	1.7	1.2	2.7	1.9
With psychopathic personality	65	43	108	2.4	2.1	2.3	3.0	2.1	2.5
With mental deficiency	64	47	111	2.4	2.3	2.3	2.9	2.3	2.6
Undiagnosed psychoses	66	42	108	2.4	2.0	2.3	3.0	2.0	2.5
Without psychosis	36	13	49	1.3	0.6	1.0	1.6	0.6	1.1
Total	2,708	2,069	4,777	100.0	100.0	100.0	123.1	99.2	111.4

* Less than 0.05 per cent.
† Less than 0.05 per 100,000 population.

show a rate of 9.9, compared with a rate of 0.6 in the preceding interval. Psychoses with cerebral arteriosclerosis include 35.1 per cent of all the admissions in this group with a corresponding rate of 45.4, a rate almost five times as large as that at 45 to 54 years.

A significant sex difference appears in psychoses with cerebral arteriosclerosis. Males and females have rates of 50.8 and 40.0, respectively. In general paralysis and the alcoholic psychoses, the males have rates of 20.7 and 17.0, respectively, again greatly in excess of the corresponding rates among females. Compared to the preceding age interval, the two latter groups of psychoses show decreasing rates, however, among males. Psychoses with cerebral arteriosclerosis are the leading category among females. Dementia praecox follows with a rate of 13.5, but little more than half the corresponding rate at 45 to 54 years. Senile psychoses, manic-depressive psychoses, and involution melancholia follow in the order named. The rate for the senile psychoses has increased greatly over that in the preceding age interval, but those for the two latter groups of psychoses show decreases.

At 65 to 74 years only the senile psychoses and those with cerebral arteriosclerosis are of numerical significance. (See Table 9.) Together they include 82 per cent of all the first admissions in this age group. There are sex differences, however. Among males the senile psychoses include 26.9 per cent of the total, compared with 43.4 per cent among females. The corresponding rates of first admission are 63.4 and 76.8, respectively, per 100,000 population. Psychoses with cerebral arteriosclerosis include 52.6 and 42.2 per cent of males and females, respectively, the corresponding rates being 123.8 and 74.6.

The same trend is evidenced in the group aged 75 years and over. (See Table 10.) The senile psychoses and the psychoses with arteriosclerosis make up 59.5 and 36.5 per cent, respectively, of all the first admissions. The senile psychoses include 51.2 per cent of the males, with a rate of 207.3 per 100,000 population, and 67.1 per cent of the females, with a rate of 232.6. Psychoses with cerebral arteriosclerosis include 43.3 and 30.2 per cent of the males and females, respectively, with corresponding rates of 175.5 and 104.6.

TABLE 8.—FIRST ADMISSIONS, 55 TO 64 YEARS OF AGE, TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, CLASSIFIED ACCORDING TO PSYCHOSES

Psychoses	*Total first admissions*			*Per cent of all admissions*			*Rate per 100,000 population*		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Traumatic	52	9	61	2.6	0.6	1.7	3.9	0.7	2.2
Senile	110	159	269	5.5	10.5	7.7	8.2	11.6	9.9
With cerebral arteriosclerosis	685	547	1,232	34.4	36.0	35.1	50.8	40.0	45.4
General paralysis	279	66	345	14.0	4.3	9.8	20.7	4.8	12.7
With cerebral syphilis	36	13	49	1.8	0.9	1.4	2.7	0.9	1.8
With Huntington's chorea	9	5	14	0.5	0.3	0.4	0.7	0.4	0.5
With brain tumor	4	2	6	0.2	0.1	0.2	0.3	0.1	0.2
With other brain or nervous diseases	10	13	23	0.5	0.9	0.7	0.7	0.9	0.8
Alcoholic	229	41	270	11.5	2.7	7.7	17.0	3.0	9.9
Due to drugs and other exogenous toxins	9	6	15	0.5	0.4	0.4	0.7	0.4	0.6
With pellagra	...	...	...	....	....	....	....	....	....
With other somatic diseases	52	40	92	2.6	2.6	2.6	3.9	2.9	3.4
Manic-depressive	149	149	298	7.5	9.8	8.5	11.1	10.9	11.0
Involution melancholia	116	149	265	5.8	9.8	7.6	8.6	10.9	9.8
Dementia praecox	94	184	278	4.7	12.1	7.9	7.0	13.4	10.2
Paranoia or paranoic conditions	23	34	57	1.2	2.2	1.6	1.7	2.5	2.1
Epileptic psychoses	20	11	31	1.0	0.7	0.9	1.5	0.8	1.1
Psychoneuroses and neuroses	8	19	27	0.4	1.3	0.8	0.6	1.4	1.0
With psychopathic personality	29	16	45	1.5	1.1	1.3	2.2	1.2	1.7
With mental deficiency	23	18	41	1.2	1.2	1.2	1.7	1.3	1.5
Undiagnosed psychoses	39	27	66	2.0	1.8	1.9	2.9	2.0	2.4
Without psychosis	13	11	24	0.7	0.7	0.7	1.0	0.8	0.9
Total	1,989	1,519	3,508	100.0	100.0	100.0	147.6	111.0	129.2

TABLE 9.—FIRST ADMISSIONS, 65 TO 74 YEARS OF AGE, TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, CLASSIFIED ACCORDING TO PSYCHOSES

Psychoses	*Total first admissions*			*Per cent of all admissions*			*Rate per 100,000 population*		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Traumatic	23	1	24	1.4	0.1	0.8	3.3	0.1	1.7
Senile	443	582	1,025	26.9	43.4	34.4	63.4	76.8	70.4
With cerebral arteriosclerosis	865	566	1,431	52.6	42.2	48.0	123.8	74.6	98.2
General paralysis	66	18	84	4.0	1.3	2.8	9.4	2.4	5.8
With cerebral syphilis	9	5	14	0.5	0.4	0.5	1.3	0.7	1.0
With Huntington's chorea	2	1	3	0.1	0.1	0.1	0.3	0.1	0.2
With brain tumor	...	...	....	....	....	....	.....	....	....
With other brain or nervous diseases	6	3	9	0.4	0.2	0.3	0.9	0.4	0.6
Alcoholic	59	4	63	3.6	0.3	2.1	8.4	0.5	4.3
Due to drugs and other exogenous toxins	3	1	4	0.2	0.1	0.1	0.4	0.1	0.3
With pellagra	...	...	....	....	....	....	.....	....	....
With other somatic diseases	20	11	31	1.2	0.8	1.0	2.9	1.5	2.1
Manic-depressive	37	37	74	2.3	2.8	2.5	5.3	4.9	5.1
Involution melancholia	21	23	44	1.3	1.7	1.5	3.0	3.0	3.0
Dementia praecox	16	35	51	1.0	2.6	1.7	2.3	4.6	3.5
Paranoia or paranoic conditions	17	15	32	1.0	1.1	1.1	2.4	2.0	2.2
Epileptic psychoses	7	9	16	0.4	0.7	0.5	1.0	1.2	1.1
Psychoneuroses and neuroses	1	5	6	0.1	0.4	0.2	0.1	0.7	0.4
With psychopathic personality	11	5	16	0.7	0.4	0.5	1.6	0.7	1.1
With mental deficiency	4	3	7	0.2	0.2	0.2	0.6	0.4	0.5
Undiagnosed psychoses	16	9	25	1.0	0.7	0.8	2.3	1.2	1.7
Without psychosis	18	7	25	1.1	0.5	0.8	2.6	0.9	1.7
Total	1,644	1,340	2,984	100.0	100.0	100.0	235.3	176.7	204.8

TABLE 10.—FIRST ADMISSIONS, AGED 75 YEARS AND OVER, TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, CLASSIFIED ACCORDING TO PSYCHOSES

Psychoses	*Total first admissions*			*Per cent of all admissions*			*Rate per 100,000 population*		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Traumatic	7	3	10	0.7	0.3	0.5	3.0	1.0	1.9
Senile	483	696	1,179	51.2	67.1	59.5	207.3	232.6	221.5
With cerebral arteriosclerosis	409	313	722	43.3	30.2	36.5	175.5	104.6	135.7
General paralysis	9	3	12	1.0	0.3	0.6	3.9	1.0	2.3
With cerebral syphilis	5	2	7	0.5	0.2	0.4	2.2	0.7	1.3
With Huntington's chorea	...	...	....	....	....	....	.....	.....	.....
With brain tumor	...	...	....	....	....	....	.....	.....	.....
With other brain or nervous diseases	...	...	....	....	....	....	.....	.....	.....
Alcoholic	5	...	5	0.5	....	0.3	2.2	.....	0.9
Due to drugs and other exogenous toxins	...	...	....	....	....	....	.....	.....	.....
With pellagra	...	...	....	....	....	....	.....	.....	.....
With other somatic diseases	7	8	15	0.7	0.8	0.8	3.0	2.7	2.8
Manic-depressive	5	1	6	0.5	0.1	0.3	2.2	*	1.1
Involution melancholia	...	...	....	....	....	....	.....	.....	.....
Dementia praecox	4	5	9	0.4	0.5	0.5	1.7	1.7	1.7
Paranoia or paranoic conditions	1	5	6	0.1	0.5	0.3	0.4	1.7	1.1
Epileptic psychoses	1	...	1	0.1	....	0.1	0.4	.....	0.2
Psychoneuroses and neuroses	...	...	....	....	....	....	.....	.....	.....
With psychopathic personality	1	1	2	0.1	0.1	0.1	0.4	*	0.4
With mental deficiency	1	...	1	0.1	....	0.1	0.4	.....	0.2
Undiagnosed psychoses	6	...	6	0.6	....	0.3	2.6	.....	1.1
Without psychosis	...	...	....	....	....	....	.....	.....	.....
Total	944	1,037	1,981	100.0	100.0	100.0	405.1	346.0	372.2

* Less than 0.05.

From the preceding discussion it is clear that the distribution of the psychoses follows characteristic trends. Under 15 years of age, all rates are numerically insignificant, but it is evident that three groups stand out from the rest—behavior disorders (without psychosis), dementia praecox, and psychoses with other brain diseases. In the interval 15 to 24 years, dementia praecox is the outstanding group. This disorder continues to grow in frequency during the next decade, with the manic-depressive psychoses also assuming numerical importance. After 35 years of age, these two groups begin to decline in frequency. General paralysis and the alcoholic psychoses begin to replace dementia praecox and manic-depressive psychoses, the former rising to their maximum rates in the interval 45 to 54 years. After 55 years arteriosclerotic disorders are the leading category, with the senile psychoses assuming prominence in the age group 55 to 64 years. These two groups continue to increase in relative frequency, but after 75 years the senile psychoses are a maximum and are much more prevalent than any other group of psychoses, including those with cerebral arteriosclerosis.

We may next proceed to comparisons from another point of view. Instead of noting the distribution of the psychoses within given age groups, we may examine the age variations within given groups of psychoses. We shall first consider all first admissions as a group.

All First Admissions.—In Table 11 the first admissions to all institutions for mental disease in the state of New York in the three fiscal years ended June 30, 1931, are classified according to age, together with average annual rates of first admissions per 100,000 general population. The average annual rate is 76.3. There is a minimum rate of 0.7 per 100,000 under 10 years of age. The rate rises rapidly to 71.0 at 20 to 24 years. It continues to grow, though more slowly, through the interval 55 to 59 years. Thereafter the rate grows with increasing rapidity, reaching 420.2 at 80 years and over.

The curves for males and females are strikingly similar, though the male rates are in excess in each interval. The average annual rate among males is 84.8 per 100,000 population. The rate rises from a minimum of 0.9 under 10 years

of age to a maximum of 436.2 at 80 years and over. The female rate, with a general average of 67.7, rises from a minimum of 0.4 under 10 years of age to a maximum of 409.0 at 80 years and over. Among males the rate rises without interruption, but among females there is a decrease from a rate of 98.2 at 40 to 44 years to 95.4 at 45 to 49 years. This is probably associated with changes among females during the involutional period. The trends are illustrated in Graph 1 (page 468).

TABLE 11.—AGES OF FIRST ADMISSIONS TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, AND AVERAGE ANNUAL RATE OF FIRST ADMISSIONS PER 100,000 GENERAL POPULATION

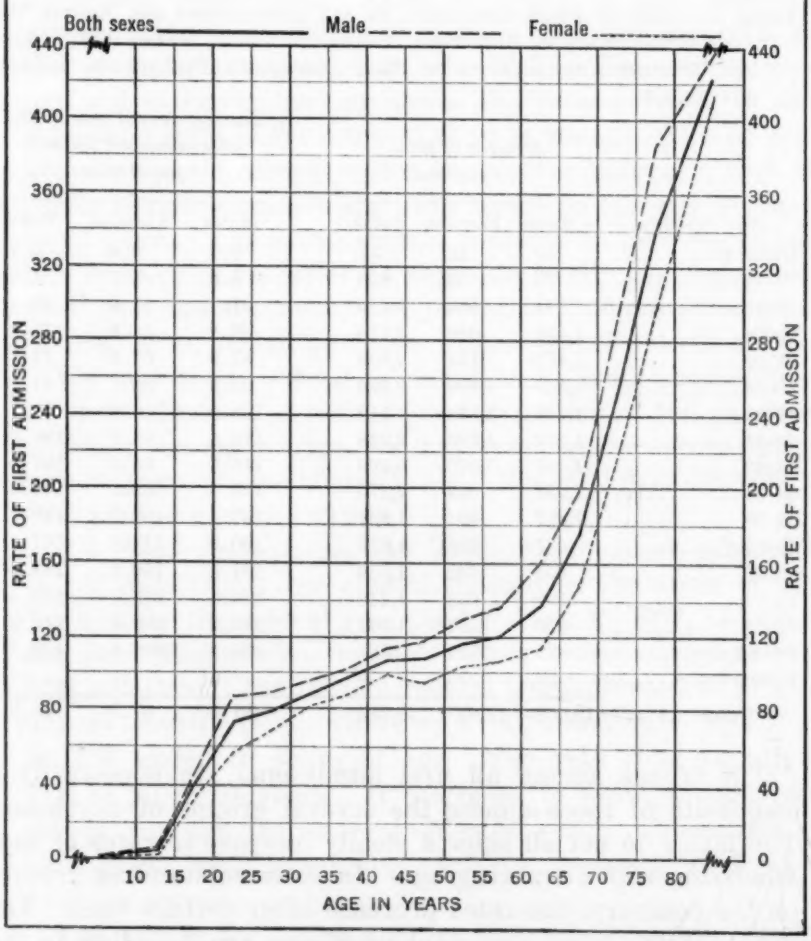
Age (years)	*Number of first admissions*			*Average annual rate of first admissions per 100,000 population.*		
	Males	Females	Total	Males	Females	Total
Under 10.....	29	12	41	0.9	0.4	0.7
10–14.....	79	59	138	4.9	3.7	4.3
15–19.....	744	542	1,286	47.1	33.6	40.3
20–24.....	1,429	986	2,415	86.8	56.2	71.0
25–29.....	1,455	1,154	2,609	87.9	67.8	77.7
30–34.....	1,528	1,298	2,826	94.3	80.7	87.5
35–39.....	1,782	1,358	3,140	109.0	86.8	98.1
40–44.....	1,632	1,296	2,928	113.5	98.2	106.2
45–49.....	1,427	1,075	2,502	118.6	95.4	107.4
50–54.....	1,281	994	2,275	128.4	103.7	116.3
55–59.....	1,027	804	1,831	136.4	106.0	120.7
60–64.....	962	715	1,677	160.9	114.8	137.4
65–69.....	854	682	1,536	201.4	150.8	175.7
70–74.....	790	658	1,448	284.4	215.0	248.4
75–79.....	553	511	1,064	385.7	299.5	338.9
80 and over.....	391	526	917	436.2	409.0	420.2
Unknown.....	29	27	56	.....	.....	.....
Total.....	15,992	12,697	28,689	84.8	67.7	76.3

The trends among all first admissions are necessarily a composite of those among the several groups of psychoses. The latter do not all show a steady increase in rates of first admission with advancing age. In some outstanding groups, on the contrary, the rates decrease after certain ages. The trends in the more important psychoses are described in the succeeding sections.

Senile Psychoses.—There were 2,514 first admissions with senile psychoses, of whom 1,050, or 41.8 per cent, were males

and 1,464, or 58.2 per cent, females. The average annual rate of first admissions was 6.7 per 100,000 population.

GRAPH 1 - AVERAGE ANNUAL NUMBER OF FIRST ADMISSIONS TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, PER 100,000 GENERAL POPULATION



Males and females had corresponding rates of 5.6 and 7.8, respectively. The complete age distribution, together with rates of first admission, are shown in Table 12.

The rates of first admission are without significance below 45 years of age. In the interval 45 to 49 years, one finds a few cases of early senile deterioration. In this interval there is a rate of 0.2 per 100,000 population. Thereafter the rate rises very rapidly, reaching a maximum of 280.9 at 80 years and over. Among males the rate grows from 0.1 at 45 to 49 years to 252.2 at 80 years and over. The female rates are constantly in excess of the corresponding rates among males. The female rates begin with a minimum of 0.3

TABLE 12.—AGES OF FIRST ADMISSIONS, WITH SENILE PSYCHOSES, TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, AND AVERAGE ANNUAL RATE OF FIRST ADMISSIONS PER 100,000 GENERAL POPULATION

Age (years)	*Number of first admissions*			*Average annual rate of first admissions per 100,000 population*		
	Males	Females	Total	Males	Females	Total
Under 30	...	...	...	.....	.....	.....
30–34	1	...	1	0.1	.....	*
35–39	...	...	...	.....	.....	.....
40–44	1	...	1	0.1	.....	0.4
45–49	1	3	4	0.1	0.3	0.2
50–54	6	15	21	0.6	1.6	1.1
55–59	16	26	42	2.1	3.5	2.8
60–64	94	133	227	15.8	21.5	18.7
65–69	174	235	409	41.2	52.0	46.8
70–74	269	347	616	97.2	113.4	105.7
75–79	257	309	566	179.2	181.1	180.3
80 and over	226	387	613	252.2	300.9	280.9
Unknown	5	9	14	.....	.....	.....
Total	1,050	1,464	2,514	5.6	7.8	6.7

* Less than 0.05.

at 45 to 49 years, and reach a maximum of 300.9 at 80 years and over.

Psychoses with Cerebral Arteriosclerosis.—There were 3,861 first admissions with psychoses with cerebral arteriosclerosis, of whom 2,193, or 56.8 per cent, were males, and 1,668, or 43.2 per cent, females. The average annual rate of first admissions was 10.3 per 100,000 population, males and females having rates of 11.6 and 8.9, respectively.

The age distribution, with corresponding rates of first admission, is shown in Table 13. There was one admission

at 25 to 29 years. At 35 to 39 years there were 9 first admissions, giving a rate of 0.3 per 100,000 population. Thereafter the rate rises rapidly and steadily, reaching a maximum of 139.2 at 75 to 79 years. There is a decline at 80 years and over, though this is probably an accidental variation.

Among males the rate rises from 0.2 at 35 to 39 years to 177.9 at 75 to 79 years. There is a similar trend among females, the rate growing from 0.4 at 35 to 39 years to 106.7

TABLE 13.—AGES OF FIRST ADMISSIONS WITH CEREBRAL ARTERIOSCLEROSIS TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, AND AVERAGE ANNUAL RATE OF FIRST ADMISSIONS PER 100,000 GENERAL POPULATION

	Number of first admissions			*Average annual rate of first admissions per 100,000 population*		
Age (years)	Males	Females	Total	Males	Females	Total
Under 25	...	...	...	.....	.....	.....
25–29	1	...	1	0.1	.....	*
30–34	...	...	...	.....	.....	.....
35–39	3	6	9	0.2	0.4	0.3
40–44	20	33	53	1.4	2.5	1.9
45–49	49	65	114	4.1	5.8	4.9
50–54	156	137	293	15.6	14.3	15.0
55–59	277	244	521	36.8	32.5	34.6
60–64	408	303	711	68.7	49.1	58.7
65–69	442	305	747	104.7	67.5	85.5
70–74	423	261	684	152.9	85.3	117.4
75–79	255	182	437	177.9	106.7	139.2
80 and over	154	131	285	171.8	101.9	130.6
Unknown	5	1	6	.....	.....	.....
Total	2,193	1,668	3,861	11.6	8.9	10.3

* Less than 0.05.

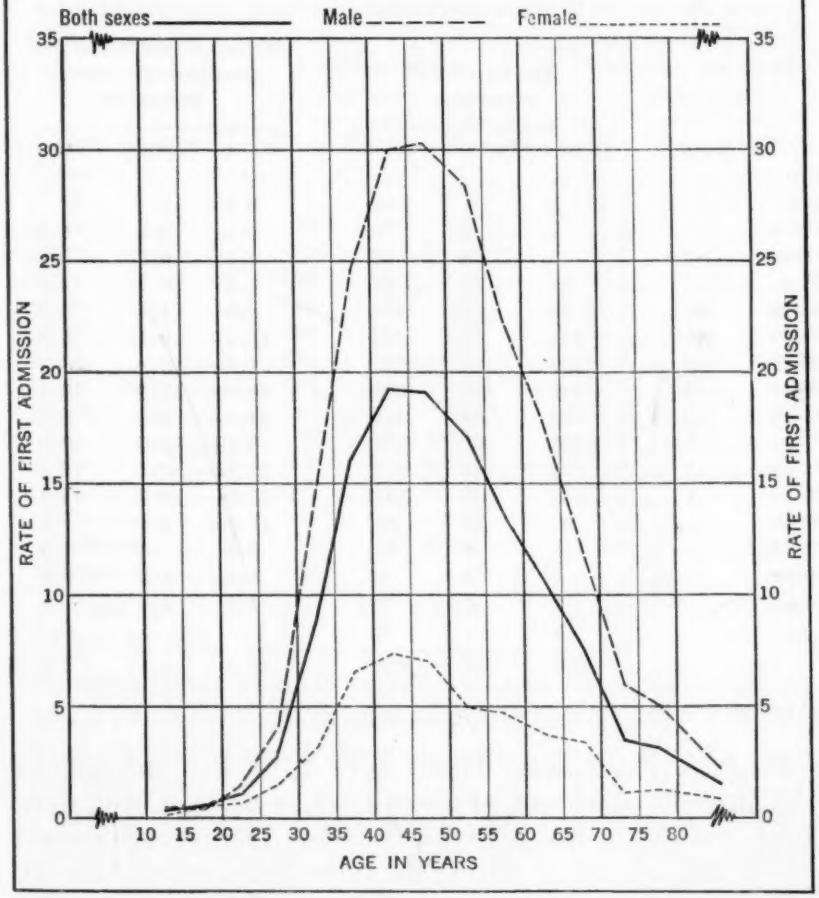
at 75 to 79 years. It is significant that after 50 years of age, the male rate is constantly in excess of that of the females.

It is also of interest that rates of first admission among males with this group of psychoses exceed those with senile psychoses through 70 to 74 years. Among females there is a similar excess through the interval 65 to 69 years.

General Paralysis.—There were 2,842 first admissions with general paralysis in the three years ended June 30, 1931, of whom 2,255, or 79.3 per cent, were males, and 587, or 20.7 per cent, females. Their age distribution, together with rates

of first admission is shown in Table 14. A graph of the latter is very distinctive. (See Graph 2.) The rate rises

GRAPH 2 - AVERAGE ANNUAL NUMBER OF FIRST ADMISSIONS WITH GENERAL PARALYSIS TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, PER 100,000 GENERAL POPULATION



from a minimum at the youngest ages to a maximum of 19.1 per 100,000 general population at 40 to 44 years, and then tapers off to a minimum of 1.4 at 80 and over. The rates

are much higher among males than among females. Among the former there is one case under 5 years of age, and 4 at 10 to 14 years, the latter providing a rate of 0.3 per 100,000 general male population. The rate rises to a maximum of 30.3 at 45 to 49 years, and then decreases to 2.2 at 80 years and over. Among females the rate rises to a maximum of 7.3 at 40 to 44 years, and then declines.

TABLE 14.—AGES OF FIRST ADMISSIONS WITH GENERAL PARALYSIS TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, AND AVERAGE ANNUAL RATE OF FIRST ADMISSIONS PER 100,000 GENERAL POPULATION

Age (years)	*Number of first admissions*			*Average annual rate of first admissions per 100,000 population*		
	Males	Females	Total	Males	Females	Total
Under 5	...	...	...	....	...	....
5–9	1	...	1	0.1	...	*
10–14	4	2	6	0.3	0.1	0.2
15–19	7	8	15	0.4	0.5	0.5
20–24	21	13	34	1.3	0.7	1.0
25–29	83	41	124	4.0	1.4	2.7
30–34	247	66	313	14.2	3.1	8.7
35–39	420	116	536	24.7	6.4	15.8
40–44	446	109	555	30.0	7.3	19.1
45–49	376	88	464	30.3	6.8	18.9
50–54	293	57	350	28.4	5.0	16.9
55–59	174	43	217	22.1	4.7	13.4
60–64	105	23	128	17.7	3.7	10.6
65–69	50	15	65	11.9	3.3	7.4
70–74	16	3	19	5.8	1.0	3.3
75–79	7	2	9	4.9	1.2	2.9
80 and over	2	1	3	2.2	0.8	1.4
Unknown	3	...	3	...	...	....
Total	2,255	587	2,842	12.0	3.1	7.6

* Less than 0.05.

Alcoholic Psychoses.—There were 1,761 first admissions with alcoholic psychoses, of whom 1,474, or 83.7 per cent, were males, and 287, or 16.3 per cent, females. The average annual rate of first admission during the three years ended June 30, 1931, was 4.7 per 100,000 population. Males and females had corresponding rates of 7.8 and 1.5, respectively. The age distribution and corresponding average annual rates of first admissions are shown in Table 15.

There is 1 first admission with an alcoholic psychosis at

15 to 19 years. In the next age interval, there are 31, giving a rate of 0.9 per 100,000 population. The rate increases steadily to a maximum of 13.0 at 45 to 49 years and then declines to a rate of 0.5 at 80 years and over. Among males the rates rise from 0.1 at 15 to 19 years to a maximum of 21.0 at 45 to 49 years, followed by a downward trend which culminates in a minimum of 1.1 at 80 years and over.

TABLE 15.—AGES OF FIRST ADMISSIONS WITH ALCOHOLIC PSYCHOSES TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, AND AVERAGE ANNUAL RATE OF FIRST ADMISSIONS PER 100,000 GENERAL POPULATION

Age (years)	*Number of first admissions*			*Average annual rate of first admissions per 100,000 population*		
	Males	*Females*	*Total*	Males	Females	Total
Under 15	...	..	...	....	...	....
15–19	1	..	1	0.1	...	*
20–24	23	8	31	1.4	0.5	0.9
25–29	77	13	90	4.7	0.8	2.7
30–34	162	27	189	10.0	1.7	5.9
35–39	224	47	271	13.7	3.0	8.5
40–44	264	65	329	18.4	4.9	11.9
45–49	253	50	303	21.0	4.4	13.0
50–54	176	32	208	17.6	3.3	10.6
55–59	145	25	170	19.3	3.3	11.3
60–64	84	16	100	14.1	2.6	8.3
65–69	47	1	48	11.1	0.2	5.5
70–74	12	3	15	4.3	1.0	2.6
75–79	4	..	4	2.8	...	1.3
80 and over	1	..	1	1.1	...	0.5
Unknown	1	..	1	....	...	....
Total	1,474	287	1,761	7.8	1.5	4.7

* Less than 0.05.

Females show a similar curve, the rate rising to a maximum of 4.9 at 40 to 44 years and declining to 1.0 at 70 to 74 years. In each age interval the male rate greatly exceeds that of the females.

Manic-Depressive Psychoses.—During the three years ended June 30, 1931, there were 3,846 first admissions with manic-depressive psychoses, of whom 1,530, or 39.8 per cent, were males and 2,316, or 60.2 per cent, females. The average annual rate of first admission was 10.2 per 100,000 population; males and females had rates of 8.1 and 12.4, respectively. The age distribution and rates of first admissions are shown in Table 16.

There is a minimum rate of 0.3 per 100,000 general population at 10 to 14 years. With a minor fluctuation at 25 to 29 years, the rates rise to a maximum of 16.4 at 35 to 39 years. Thereafter they decline to 0.9 at 80 years and over. The male trend fluctuates abruptly at times, but in general there is an increase with age to a maximum rate of 14.9 at 50 to

TABLE 16.—AGES OF FIRST ADMISSIONS WITH MANIC-DEPRESSIVE PSYCHOSES TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, AND AVERAGE ANNUAL RATE OF ADMISSIONS PER 100,000 GENERAL POPULATION

Age (years)	*Number of first admissions.*			*Average annual rate of first admissions per 100,000 population*		
	Males	Females	Total	Males	Females	Total
Under 10	...	...	...	....	....	....
10–14	5	5	10	0.3	0.3	0.3
15–19	105	178	283	6.6	11.0	8.9
20–24	223	308	531	13.6	17.6	15.6
25–29	165	339	504	10.0	19.9	15.1
30–34	172	337	509	10.6	21.0	15.8
35–39	192	333	525	11.7	21.3	16.4
40–44	181	265	446	12.6	20.1	16.2
45–49	145	197	342	12.1	17.5	14.7
50–54	149	166	315	14.9	17.3	16.1
55–59	95	95	190	12.6	12.7	12.6
60–64	54	54	108	9.1	8.8	8.9
65–69	21	25	46	5.0	5.5	5.3
70–74	16	12	28	5.8	3.9	4.8
75–79	3	1	4	2.1	0.6	1.3
80 and over	2	...	2	2.2	....	0.9
Unknown	2	1	3	....	....	....
Total	1,530	2,316	3,846	8.1	12.4	10.2

54 years, and a decrease thereafter. The female trend is steadier and probably more reliable, the rates growing from 0.3 at 10 to 14 years to a maximum of 21.3 at 35 to 39 years, and decreasing regularly thereafter. Beginning with the interval 15 to 19 years, the female rate exceeds that of the males through 55 to 59 years. Thereafter the male rate is generally in excess, though beyond 75 years the rate can hardly be considered reliable.

Dementia Praecox.—First admissions with dementia praecox during the three years ended June 30, 1931, totaled 7,539, of whom 4,163, or 55.2 per cent, were males and 3,376, or 44.8

per cent, were females. The females were significantly older than the males, the average ages being 36.5 and 31.8 years, respectively. The average annual rate of first admissions was 20.1 per 100,000 general population. The males had a rate of 22.1, this being significantly in excess of that of the females (18.0). The age distribution and corresponding average annual rates of first admission are shown in Table 17, and are illustrated in Graph 3 (page 476).

TABLE 17.—AGES OF FIRST ADMISSIONS WITH DEMENTIA PRAECOX TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, AND AVERAGE ANNUAL RATE OF FIRST ADMISSIONS PER 100,000 GENERAL POPULATION

Age (years)	*Number of first admissions*			*Average annual rate of first admissions per 100,000 population*		
	Males	Females	Total	Males	Females	Total
Under 5	...	...	....	....	....	....
5–9	1	...	1	0.1	....	*
10–14	15	12	27	0.9	0.8	0.8
15–19	392	180	572	24.8	11.2	17.9
20–24	858	403	1,261	52.1	23.0	37.1
25–29	836	487	1,323	50.5	28.6	39.7
30–34	620	544	1,164	38.3	33.8	36.0
35–39	590	541	1,131	36.1	34.6	35.3
40–44	350	436	786	24.3	33.0	28.5
45–49	233	308	541	19.4	27.3	23.2
50–54	149	234	383	14.9	24.4	19.6
55–59	62	130	192	8.2	17.3	12.8
60–64	32	54	86	5.4	8.8	7.1
65–69	15	24	39	3.6	5.3	4.5
70–74	1	11	12	0.4	3.6	2.1
75–79	3	2	5	2.1	1.2	1.6
80 and over	1	3	4	1.1	2.3	1.8
Unknown	5	7	12	....	....	....
Total	4,163	3,376	7,539	22.1	18.0	20.1

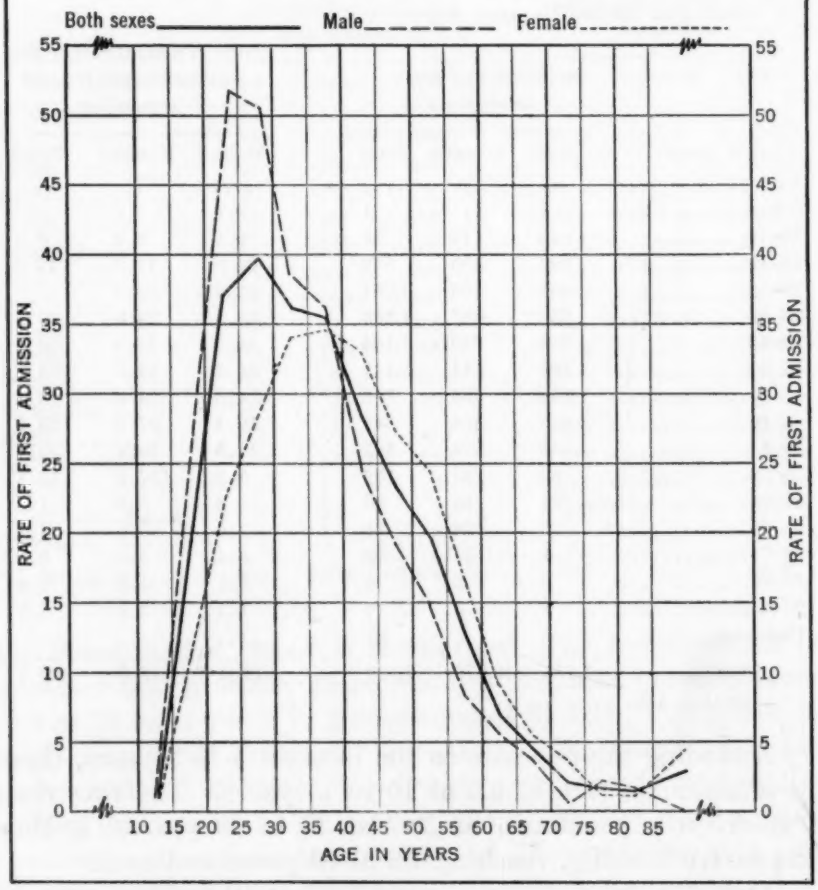
* Less than 0.05.

Excluding the one case in the interval 5 to 9 years, there is a minimum rate of 0.8 at 10 to 14 years. The rate rises rapidly to a maximum of 39.7 at 25 to 29 years. It then decreases steadily, reaching 1.8 at 80 years and over.

Among males there is a rate of 0.9 at 10 to 14 years, and a rapid rise to a maximum of 52.1 at 20 to 24 years, followed by a general decline to minimum rates at old age. Among females the rate rises from 0.8 at 10 to 14 years to 34.6 at 35

to 39 years. It decreases thereafter to 1.2 at 75 to 79 years. There is a rise, probably accidental, in the rate at 80 years and over.

GRAPH 3 - AVERAGE ANNUAL NUMBER OF FIRST ADMISSIONS WITH DEMENTIA PRAECOX TO ALL INSTITUTIONS FOR MENTAL DISEASE IN THE STATE OF NEW YORK DURING THE FISCAL YEARS 1929 TO 1931, PER 100,000 GENERAL POPULATION



Up to 35 to 39 years the male rate exceeds that of the females. Thereafter the latter is in excess through the interval 70 to 74 years.

BOOK REVIEWS

INFANT BEHAVIOR; ITS GENESIS AND GROWTH. By Arnold Gesell and Helen Thompson, assisted by Catherine Strunk Amatruda. New York: McGraw-Hill Book Company, 1934. 343 p.

Those who have followed closely the long series of reports from the Yale Clinic of Child Development on the developmental sequences in infant behavior over the past decade can hardly help but be impressed, not only by the quality of the work itself, but also by the progress that the human eye makes in the art of seeing. Although the use of the cinema has greatly facilitated this progress, even its faithful records can only provide the opportunity for observation. Dr. Gesell's oft-repeated assertion that the behavior patterns of the infant grow and become more finely elaborated with advancing age might well be extended to include the vision of the adult who observes the behavior. With added experience in learning what to look for, the vision grows, and details at first overlooked stand out in clear relief.

This volume by Gesell and Thompson bears eloquent testimony to that growth. Its relationship to earlier publications from the same laboratory reminds the reader of one of Gesell's own vivid comparisons of the behavior of an infant at forty weeks with that of the same infant at four weeks. If we may borrow a phrase as well as an analogy, we might say that the book does not represent a new scientific construct, but a later stage of scientific morphology.

The major part of the volume is given up to a very detailed account of the developmental changes in the responses of infants to twenty-four simple situations. A total of 524 examination records from 107 infants provide the data. From the records of these examinations, it was possible to select 1,024 separate items, each item representing a particular way of responding to one of the situations. Only those items were included that showed a consistent trend with age. Thus, when a small hand bell was placed before the infant, a total of 78 different responses, each showing some developmental trend, were observed. Examples are: *approaching with one hand,* which increases in frequency from 23 per cent at sixteen weeks to 96 per cent at fifty-six weeks; and *bringing bell to mouth,* which makes its first appearance at twenty weeks, increases to 90 per cent at twenty-eight weeks, and thereafter shows a steady drop to 4 per cent at fifty-six weeks.

As compared with the earlier reports, the present one is characterized by more precise description of the behavior situations used and by much greater minutiæ in the presentation of results, all of which are given in the form of tables showing the percentage of cases that display each of the 1,024 listed responses at each of fifteen age-levels from four to fifty-six weeks. The authors state that this volume is designed in part to accompany the monumental collection of photographs that make up Gesell's two-volume *Atlas of Child Behavior*, for which it serves as a descriptive guide to the interpretation of the photographs.

No attempt is made to combine the items into a single score or developmental index, and the statistical evaluation of the results has been postponed to a later volume which is promised for the near future.

FLORENCE L. GOODENOUGH.
Institute of Child Welfare, University of Minnesota.

DEVELOPMENTAL PSYCHOLOGY; AN INTRODUCTION TO THE STUDY OF HUMAN BEHAVIOR. By Florence L. Goodenough. New York: D. Appleton-Century Company, 1934. 619 p.

This book is one of the Century Psychology Series and its scope may well be described in the author's opening words to the student: "A first book in psychology is in your hands. Its aim is to help you to learn something about how human beings behave and why they behave as they do." While it is obviously arranged as a textbook for the college student, it is admirably suited for use in discussion groups of adults, especially for groups of intelligent young mothers for whom the scientifically stimulating book is more acceptable than the average parent-education literature. Without sacrificing scientific accuracy or clear statement of facts, the author has achieved a vivid, interesting, and readable presentation of her material. From the opening chapters—in which the statement is made that the fertilization of the egg cell is not strictly the beginning of life, but that life is continuous from one generation to another—to the closing chapters on old age, the developmental aspect of psychology is the clearly defined thread throughout.

The twenty-seven chapter headings are in themselves a dramatic sequence with a beginning, a middle, and an end—*e.g.*, *The Behavior of the Unborn Child; The Social Reactions of Infants; General Intelligence and its Measurement in Early Childhood; The Development of Personality and Character in Later Childhood; Educational and Vocational Guidance for the Adolescent; Motivation of Behavior at the College Level; Adult Behavior and Social Customs;* and *Old Age.* Pertinent and practical questions introduce each chapter for the pur-

poses of stimulating curiosity and orienting the student in regard to the material—*e.g.*, "When and how does the baby begin his learning?" "How does the study of the language of twins help us to understand the social factors in language development?" "What are some of the advantages of an 'intelligence test' as compared to casual observation?"

References to the most suggestive studies in the field of child development and their practical application are numerous throughout the book, accentuated by plates, graphs, charts, and pictures. We read of the intellectual factors in children's drawings, of factors that influence the development of language in children, of the development of color vision in infancy, and of habit breaking. The subtle humor in *The Psychoanalytic View of Children's Emotions* makes it an especially attractive study. Also for especial commendation is the same point of view presented in the material on the adopted child in the chapter on general intelligence and its measurement, a subject so often omitted in spite of its clinical importance. In this connection the author might have added to the notes on the Furfey, Linfert and Hierholzer, and Bayley studies a note that the Gesell scale for babies has proved of good diagnostic value clinically, especially when used at the twelve-months level, in predicting development for the field of adoption as confirmed by the actual development of the child. A good subject index concludes this most human as well as academic publication, which may well quicken the student to follow the author's own advice: "Don't stop with finding out what the book has to say."

VIOLA M. JONES.

Boston Psychopathic Hospital.

THE MENTAL-HEALTH EMPHASIS IN EDUCATION—A QUALITATIVE STUDY. By Henry C. Patey and George S. Stevenson, M.D. New York: The National Committee for Mental Hygiene, 1934. 91 p.

This splendid report, a reprint from the *American Journal of Orthopsychiatry*, is based upon a larger unpublished study. It represents a systematically outlined, tightly compressed statement of educational and mental-hygiene assumptions, principles, functions, procedures, practices, and needs. The authors have attempted to take a broad view of education and have succeeded admirably.

The study is divided into five parts: *"The Mental Hygiene Approach; Identities of Mental Hygiene and Education; Mental Hygiene Functions of the School; Professional Services and Training;* and *Conclusions and Recommendations.* There is a five-page bibliography listing the books and articles referred to in the report.

A few of the many principles wisely stressed by the authors are:

1. "Progress depends on new integrations of viewpoints."

2. Mental-health values are diffused through and are influenced by all human activities.

3. It is not as helpful to classify certain phases of endeavor as belonging to mental hygiene as it is to consider the criteria by which mental health can be judged in a wide variety of situations.

4. When both are functioning properly, education and mental hygiene are identical. Their common goal is "the constructive development of the individual's potentialities for meeting life's situations satisfactorily." The school has a large, but partial responsibility in attaining this goal; its entire organization and administration should be considered from the point of view of the "integrating construct," mental hygiene.

Scattered through the booklet are numerous constructive recommendations, including these:

1. A satisfactory criterion of mental hygiene is needed.

2. Further study, analysis, and evaluation should be made of: (a) professional training courses; (b) the place of school in society; (c) the mental-health implications of various school subjects and activities.

All such efforts should be coördinated and interpreted.

3. There is need of methods of training and sensitizing those who are working in the regular school channels.

4. Since the child is indivisible, the teacher should be the integrating factor in as many educational-hygiene situations as possible. She should have a voice in determining policies and should feel a sense of security.

5. There is a general need for correlation and integration. Examples can be found in such professions as teaching, visiting-teacher work, psychology, psychiatry, and general medicine. Opposite page 72 is a useful chart which shows in visual form common elements as well as differences in such fields. Friends of the authors report that the drawings on the covers of this attractive booklet represent Mrs. Patey's artistic impression of these relationships.

6. Future training should consider the real needs of human beings and the common elements in the professions.

7. There is need of finding new ways of informing boards of education and the general public of safe mental-hygiene principles. Additional ways of securing public support and of reforming public attitudes must be discovered.

This report is a valuable addition to the literature in the field of educational hygiene. It should be read by advanced students as well as by specialists and leaders connected with education. If the prin-

ciples and recommendations of the study are carried out, educational aims, attitudes, and methods will be favorably influenced on a wide scale.

FRANK ASTOR.

New York City Bureau of Child Guidance.

A CONTRIBUTION OF MENTAL HYGIENE TO EDUCATION. With a Foreword by Ethel S. Dummer. Program of the Mental Hygiene Division of the Illinois Conference on Public Welfare, Chicago, October, 1933. 64 p.

Of the three papers that make up this little book, the first—*Education Through Play*, by Bertha Schlotter—is an interesting account of an experiment instituted at the Lincoln School in Illinois, in which recreation is made the basis of an educational training for a group of children who had been considered uneducable. Miss Schlotter's paper not only describes the way in which this training is carried out, but gives something of the philosophy upon which it is based, which is summed up in her final paragraph in the statement, "Play for play's sake and fun for fun's sake, has been uppermost in the play leaders' minds. Through informality and joy, repression has given way to expression, and the child thinks and chooses for himself." A simple play situation has been created in which these defective children have found a medium for the expression of their very limited capacities, and through this expression have been stimulated to growth, some degree of which is possible even for them.

In the second article, *Spontaneity*, Dr. Adolf Meyer gives a most lucid and stimulating statement of his philosophy regarding the nature of man, his organization, and differentiation. He criticizes those tendencies in psychopathology which emphasize cut-and-dried concepts, indicating that the study and knowledge of man is settled—attitudes that may hide the more essential and more spontaneous features of living. This happens when emphasis is placed on "what is wrong," to the neglect of the more positive aspects of life.

Spontaneity in human nature deserves a very positive position in our study of man. "The spontaneity of the person—that which he can do, and actually does, on his own and in his own way, without particular external prompting or coercion—is what interests us above everything." Growth, or waking up, is regarded as a positive process, and the "philosopher who thinks that man will not act unless prompted by pain and conflict maligns human nature."

The spontaneity of the person has to do with the use and adaptation of that person's own capacity—what he can do on a moment's notice—what he can do over a period of time, and always in relation

to the disciplining of this spontaneity or action by his own experience. The matter of balance and discipline in relation to spontaneity is fully discussed.

The fundamental element in spontaneity is naturalness, and a study of the nature of any particular spontaneity must start with the immediate and actual data instead of focusing attention on "reaching out for something behind it all." Interest must focus on what people are, rather than on what they have been—what their spontaneities are, irrespective of external conditions to which the person is responding or has responded.

On this theme Dr. Meyer gives his own penetrating point of view. The paper is a stimulating philosophical presentation which deserves a much wider distribution than is possible in its present form. Only a complete reading of it can give one an adequate appreciation of its value.

Some Unnoted Aspects of Therapy, by Scott Buchanan, the third paper in the book, is an interesting attempt to apply the philosophical contributions of Mary Boole to some of our present problems in human nature, particularly in relation to therapeutic work. Buchanan draws an interesting analogy between many phases of present-day life and the ritualistic and frankly magical activities of "primitive" people. Some modern therapeutic procedures he sees as attempts to adapt ritualistic procedures to the solution of some of our present human problems. He goes on to discuss ritualistic behavior as a means of bridging the gap between the old and the new and unfamiliar, and shows how some of these same rituals have perpetuated themselves in modern life, both in the play of the child and in many religious observances of the adult. In both earlier cultures and those of the present day the same purpose is served—control is acquired over the unknown.

He brings out the relation that exists between mathematics and rituals, pointing out that both provide a form of thought and behavior that can be repeated with "wide ranges of material" and that "give thereby significance and direction to whatever they touch," and he advises a therapeutic use of the teaching of mathematics because "mathematics represents a natural and normal mode of human thought."

He points out certain parallels between sacramental systems and some of the Freudian concepts, indicating that growing out of each are certain insights that have something of the same value to the individual—that as psychoanalytic insights become clearer, they will demand a reinstatement of the insights implied in the terms "soul" and "God," even though these are reinstated with different words

attached. He implies that psychoanalysts operate in a somewhat unreal world when he refers to them as the "Robinson Crusoes of modern therapy" and points out "the need to prepare for the time when they come back to civilization."

FREDERICK W. ALLEN.

Philadelphia Child Guidance Clinic.

A STUDY OF SCHOOL HEALTH STANDARDS. By Anette M. Phelan. New York: American Public Health Association, 1934. 250 p.

Ever since the publication of the 1867–68 report of the U. S. Commissioner of Education, which included the two papers, *Plans for Boston Grammar School Houses,* by J. D. Philbrick, and *Improvements in Plans and Construction of Public School Houses in Philadelphia,* by Edward Shippen, research into the general problem of promoting the physical welfare of the school child has gone on fairly continuously. Hardly any national organization of any eminence in the field of education in the past half century has failed to contribute to the better surveying of this field. Between 1890 and 1899 several outstanding American educational periodicals opened their columns to the publication of research work by investigators in the general field of school hygiene. Within this decade no less than twelve studies in the growth of children were reported by Bowditch or his students, and at the 1898 meeting of the N. E. A., nine papers were presented on various aspects of this increasingly important problem. Simultaneously, William H. Burnham, pioneer in educational hygiene in this country, was stimulating his students to go out into the educational world as *voces clamantes in deserto* for hygiene, and was himself contributing indefatigably to the new evangel.

Beginning somewhat modestly with two objectives—to protect children from fire hazards and from the supposedly poisonous effects of carbon dioxide in poorly ventilated schoolrooms—the movement has ramified into innumerable highways and byways of school and child life, culminating in efforts to discover and to universalize minimum and optimum standards of educational hygiene for informative and guidance purposes.

The author of the present volume prefaces her contribution to the development of school health standards by an introductory section devoted to a review of the research work that has been done during fifty years of gradually developing interest in the field of child health and welfare. She finds abundance of evidence that, in striking contrast to the narrowness of the seventies and eighties, school health work to-day has evolved into the maintenance of a program of healthful living that embraces every aspect of the school experience—physi-

to the disciplining of this spontaneity or action by his own experience. The matter of balance and discipline in relation to spontaneity is fully discussed.

The fundamental element in spontaneity is naturalness, and a study of the nature of any particular spontaneity must start with the immediate and actual data instead of focusing attention on "reaching out for something behind it all." Interest must focus on what people are, rather than on what they have been—what their spontaneities are, irrespective of external conditions to which the person is responding or has responded.

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cal, mental, emotional, and social—and that seeks expression and codification in working standards that can be adopted widely by school administrators.

Unfortunately, however, the literature and survey material also yield the disconcerting evidence that while effective operation of some aspects of a general health program can be discerned almost anywhere in our vast system of education, a comprehensive and effective program is probably nowhere to be found. In large part the wide discrepancy between the actual and the ideal in health standards is due to differences of opinion among the schoolmen as to what constitutes desirable standards to be included within the scope of school health procedures. Dr. Phelan has set herself the task of determining those standards on which there is good unanimity of educational opinion, and to subject controversial standards to experimental technique in order to determine their desirability.

An inventory list of tentative standards was prepared from available research studies and from texts and surveys of practice in the field of school health. About one thousand standards were derived from these sources. Combining and reclassification reduced this number to 242. This list, under the title, *Tentative Standards for a School Health Program,* was forwarded to 62 carefully selected leaders in school health work, with a rating sheet on which each rater was invited to indicate on a 5–0 scale his opinion of the essentiality or the nonessentiality of the individual standards proposed. Fifty-two of the 62 experts rated the standards and returned the sheets. Thirty-three of the tentative standards were selected for further study, since they received a low median rating.

The bulk of Dr. Phelan's book is devoted to a detailed examination of the 33 unaccepted standards from the point of view of present trends and practices in school health and in the light of the findings of research. The author groups these low-ranking standards for purposes of treatment under such chapter headings as *Standards Related to Health Service by Professional and Lay Workers* (typified by No. 8: "The school should provide adequate psychological service for determining the ability levels of children"); *Standards Related to the Hygiene of the School Plant* (typified by No. 57: "Fifteen square feet of floor space, and 200 cubic feet of air space should be allowed as a minimum for each child"); *Standards Related to Classification of Children and Special Education* (typified by No. 20: "The school should provide open-air classes for severely run-down and undernourished children"); *Standards Related to the Health of Teachers* (typified by No. 124: "The school should provide a thorough health examination for all teachers in service"); and *Standards Relating to Health Education Materials* (typified by No. 144: "The school should

supply new and replacement materials on the request of the teacher'').

The appendix includes a complete list of the standards and an exhaustive bibliography of the sources used in their selection. Other full biblographies are presented intermittently throughout the volume, according to the special problem or group of problems under immediate consideration.

LAWRENCE A. AVERILL.
State Teachers College, Worcester, Massachusetts.

A SOCIAL BASIS OF EDUCATION. By Harold S. Tuttle. New York: Thomas Y. Crowell Company, 1934. 589 p.

The author of this somewhat lengthy volume has attempted an exposition of a philosophy of education. The central theme may best be indicated by the following quotations (p. 5): ''The service of sociology to education will not be fully realized until, in the judgments, the habits, and the attitudes of every teacher and every parent, the significance of the social aspects of education holds an equal place with that of its individual aspects. . . . Education can serve its social purpose only by consciously cultivating social interests and motives.'' ''It is in the hope of stimulating, on the part of educators, in school and out, increased emphasis on the social outcomes of education, that the author has prepared this treatise.''

This general thesis is treated from several angles. In Part I, the contribution of sociology in clarifying the aims of education is discussed. Particularly should sociology furnish a means of continuous and progressive analysis of aims that are in harmony with social changes. Part II deals with the psychological laws pertinent to the clarification and attainment of developmental objectives. A great deal of the education of the child is unwittingly governed by social agencies other than the school; and this aspect of the broad problem of education is discussed in Part III. The specific task of the school is considered in Part IV.

The reviewer is in sympathy with the spirit of the book. Educational practice has, in a particular sense, undoubtedly been *individualistic* in emphasis; so that there is a real need for readjusting content and method with a view to increasing the social contribution of our schools and colleges. The author's treatment of this problem, however, while very timely and extremely challenging, appears to have distinct limitations. In pointing out a few of these, it may be possible to indicate more definitely the contribution offered by Professor Tuttle, without undue elaboration of particular points.

Any discussion of the aims of education is likely to involve great difficulties. On the whole the author preserves a commendable clarity and simplicity in his sociological approach to this problem. But cer-

tain apparent contradictions detract considerably from the value of Part I of his book. For example, on page 6 he states that "psychology has nothing to say about the objectives of society." Yet on pages 2 and 23, he bases judgment concerning the "good social order" on the laws of individual psychology. The law of effect, we are told (p. 25), when properly understood, will revolutionize our whole program of education and most of our philosophy. So, too, there is a distinct enthusiasm for modern "discoveries"—such as (p. 24) "the relation between the nervous system and conduct"(!)—and a somewhat ruthless treatment of earlier points of view. Jeremy Bentham would not appreciate the author's "New Hedonism" (pp. 24 ff.) as presented in contrast to the old, which said: "See that fuzzy yellow creature on the window! If it attracts you, take it." In this section particularly, one wonders how far the author is really acquainted with the "felicific calculus," or with the classical treatment of "feeling" by psychologists such as James Ward. In striving to elaborate the affective bases of behavior to give fundamental place to "satisfaction," "the good of one's fellows," and the like, it almost appears that the sociologist has lost himself, and has become an advocate of egocentric-individualism.

In Part II, one is treated to a discussion of psychological processes. This is always a difficult field, particularly for psychologists. One can admire the useful common-sense emphases made by the author in dealing with the responsibilities of education, the need for careful control of environmental consequences of a child's behavior, the importance of developing useful interests and worth-while habits, and so forth, and yet, at the same time, decry such positive affirmations as: "Sensations are definitely limited to the nerves which have become adapted to certain forms of irritation or stimulation" (p. 142); "Modern psychology has demonstrated quite conclusively that . . . each skill involves a particular arc or system. Whenever that skill is again needed, the same neural system functions. For any other skill a different system must be developed" (p. 153); "Skills are attained in proportion as resistance in appropriate neural arcs is diminished" (p. 158).

Parts III and IV address themselves to a much more positive and constructive view of education than would be expected from the preceding sections of the book. They present the social aspects of education in a very challenging and comprehensive manner, and will amply repay careful study by all who are interested in liberalizing our educational outlook. Discussion of the topics and problems included in these sections would undoubtedly stimulate teachers in training and in the field. To assist such discussions, the author has

issued a 19-page *Teachers' Manual,* which should prove to be of value in organizing class work based on the text.

W. Line.

University of Toronto.

The Sex Life of the Unmarried Adult. Edited by Ira S. Wile, M.D. New York: The Vanguard Press, 1934. 320 p.

Birth Control: Its Use and Misuse. By Dorothy Dunbar Bromley. New York: Harper and Brothers, 1934. 304 p.

American Encyclopedia of Sex. By Adolph F. Niemoeller. New York: The Panurge Press, 1935. 277 p.

These three unique books stand out above the swollen flood of sex literature let loose by recent court decisions. They are striking and diversified examples of the apparent determination of authors to lift the fog of ignorance and misconception and hypocrisy that has overlaid the field of human sexuality throughout the era of prohibition and superstition now drawing to a close. Each one carries conspicuous scars of the shackles as evidence of things past; but still each one says its say with a freedom that would have been unthinkable even five years ago. And not one bears that protective legend: "To be sold only to members of the learned professions." The general public can now learn what there is to be known; and if it fails to banish a good part of the troubles of sex, it has no one to blame but itself.

The various aspects of sex study, however, are not equally advanced, and the three books under review exemplify three different types of presentation. The first—consisting of eleven essays, by as many authors, on the sex life of the unmarried adult—is a tentative, pioneer work. In large part, it states and clarifies problems—many of which have been conventionally regarded as not even existent—rather than solutions. The second, which deals with birth control, discusses some unsolved problems, to be sure; but it also states many conclusions and reflects the fact that birth control is well beyond the pioneer stage. That its author is a competent and informed journalist, able to organize a well-rounded treatment and put it into simple and highly entertaining prose, is in itself evidence that the subject is nearing maturity. The third, an alphabetically arranged dictionary of all words and phrases pertaining to sex (except the four-letter words still taboo to all but the most venturesome of publishers), is a typically definitive record of an advanced and well-worked field of study, which it covers and presents in an extremely concise and final form. The subject of sex is broad enough, then, for us to have simultaneously before us a disjointed report of pioneer exploration, an integrated work of literary exposition, and a comprehensive piece of special lexicography. It is to be hoped that all of the thirteen authors

involved will read the contributions of the others before they go on to new efforts.

Dr. Wile's symposium is at once the least satisfactory and very likely the most important of these books, for it opens for future discussion and study a matter of the utmost personal, biological, psychological, and social importance. Many of the contributors deal largely with the historical aspect of the subject before saying how they regard the current phenomena of unmarried sexuality; and here they do well, for it is obviously useful and often relatively easy to see what has happened in the past. But when they attempt to discuss the present and the desired or dreaded future, their words seem less convincing. There is an almost fatal lack of precise knowledge of what is really going on, a great dearth of statistics; there is in almost every mind a more or less refractory core of moralistic or personal prejudice; there is a strongly felt lack of reliable standards for application to both present and future.

None the less, they forge bravely ahead, as pioneers and explorers should, and every essay will be found to contain something of interest. In his introductory remarks Dr. Wile states that in the United States about one-third of the people above the age of fifteen years are unmarried, and that only 294,297 of the 1,525,960 professional women have husbands. From such centrally significant, though meager, statistics he goes on to discuss the broader phases of the subject in his witty and entertaining, if somewhat flamboyant, style. His attitude seems to be expressed in his statement that "the growing freedoms of to-day have emanated as a protest against the prolonged social endeavor to make all sex shameful, fearful, unholy, and unclean. Prohibition has declined in influence in favor of rational guidance in the light of biologic principles. . . . Unmarried adults appreciate that sex is the source of life, but believe that a sexless life is a mockery after biologic maturation, because it is contrary to nature." This is a simple, clear, and sensible statement with which the stated conclusions of but few of the other authors are really in accord, although most of them might be willing to subscribe to it as a very general principle.

Margaret Mead, for example, in her chapter on anthropology, gives a comprehensive review of the astonishing variety of sex customs among savage cultures, illustrating the frightful lengths to which poor human nature will go under the compulsion of the mores; and she suggests that these "contrasting and uncomparable attitudes," however unbiological or apparently "contrary to nature," are in reality "particularly congenial to and normal for certain human temperaments." This discussion throws little if any light on the problem under civilization, where a prime fact is the relative weakness of

taboo and the lack of formulated, practically unanimous behavior patterns. In the articles on psychology, sociology, and economics, Ernest Groves, Ernest Burgess, and Mary Beard endeavor to analyze conditions in our own culture, which, unlike that of the savage tribe, is highly heterogeneous. It is impossible to summarize their multifarious commentary—they simply don't know what exists or what ought to exist; but here are a few of their definite pronouncements:

> Groves: "The comfortable assumption that sex can be kept quiescent until marriage invites it to come forth, is at an end. . . . There is no certainty of ultimate marriage, especially for young women. . . . There is no standard sex career before marriage. . . . The mores themselves are in confusion. . . . Sex energy is put to other uses . . . business, philanthropy, science, religion. . . . It acts like water turned away from the river channel and directed by the canal to the mill wheel[!] . . . If monogamic standards are to be maintained, it must be made easier for young people to marry."

> Burgess: "The single person, with an independent status, is peculiarly a phenomenon of modern times. . . . All evidence seems to point to a greater or less decline in the emphasis upon chastity before marriage. . . . Research into the sex life of the single woman is still in the pioneer stage. . . . Marriage still remains the preferred and idealized type of sexual relationship . . . [but other types] are to be interpreted in the light of a new Puritanism which places its stress not upon the externals, but upon the inner realities of personal relations."

> Beard: "The Fascist movement in Germany, as in Italy and Japan, is essentially a dynamic of unmarried males. . . . The Third Reich is perhaps the first example of a nation dominated by convinced bachelors. . . . Often the European states have been wrecked by unmarried hordes. . . . The old French monarchy was led to economic ruin partly through its efforts to finance the vast aggregation of religious celibates in its midst. . . . The Greek philosophers represented a 'brain trust.' . . . Through companionate liaisons with thoughtful men, unmarried Greek women perhaps more than wives extended the reaches of intellectualism. . . . Through the [monastic] priesthood males escaped military service . . . and family duties. . . . The Crusades represented a mass movement of devout celibates [in part]. . . The discovery of America opened a fresh theater in which unmarried adults could play their various rôles. . . . [Then the Industrial Revolution and feminism came, favoring celibacy] . . . yet the age-old horror of overpopulation lifts its hoary head . . . and surplus men and young women, impressed by the futilities of their lives, dally with the idea of war."

In their chapters on biology and medicine, Professor Ingalls and Dr. R. L. Dickinson respectively come to closer grips with the subject and together present in outline the physical foundation which is absolutely necessary for any successful scheme of sex ethics and behavior. It appears that a general failure to understand and accept as basic

the biological view of sex underlies the ultimate futility of authors who in the end come to rest upon the treacherous quicksands of "sublimation"—a mythical process which Ingalls says cannot "be counted on for material aid in any social system."

Dickinson, in summarizing the data derived from his own lifetime of practice and from associated investigations, offers the reader the most forthright and useful chapter in the book. He also rejects "sublimation" and is hospitable to a new deal in sex relations, for "a philosophy and a régime that has wrecked so many lives and marriages cannot be deemed a success." In the course of his article he states clearly the new, scientific attitude on such matters as experimentation, frankness, and lessening of penalties, physical and social; doctrines of shamefulness and perversion; sterilization and abortion; virginity and auto-eroticism; premarital experience and abstinence; the church vs. science and sex; dwindling prostitution and growing sex knowledge and sex freedom, within and outside of marriage. He concludes that "non-marriage and non-mating are social and biological thwarting," that "the traditional degradation of the sex function is doomed," and that "the right of woman to make her own decisions is on the way."

In his article on law Morris L. Ernst, champion of many censorship battles, traces what he calls the "Greco-Jewish amalgam" treated with "doses of Roman-Anglo-Saxon Law," as cause of the current "conflict between our mores and our laws" and exposes the consequent nullification. In the course of his witty and learned discussion, he touches on the laws regarding fornication and adultery, breach of promise, alienation of affections, homosexuality, birth control, legitimacy of children, censorship, prostitution, and on the Mann Act. To clear the ground for affirmative action on clinics, and so forth, he advocates repeal of all this mass of negative and largely futile or even debasing legislation.

Horace M. Kallen reviews the history of changing sex morals and, like a good philosopher, begins with definitions of terms, including "morals," "fallen woman," "sinning," "honor," "innocence," "good woman," and so forth. He notes the trends of modern sexology and psychology ("never before such erotica"), the answers to his own and other questionnaires, modern behavior in life and in books. And he concludes that "the morals of sex are a mystery." He cannot decide whether a maximum or a minimum of regulation is best, and cites post-Revolutionary "chaos" in Russia as evidence that Ellis and Russell are probably wrong in teaching that sex apart from child-bearing is a private matter. Such is philosophy.

The last essays are Robert Morss Lovett's historical review of unmarried sex in English literature, which brings him to the sad fear that "romantic love, that passion peculiar to the unmarried adult, is

destined to decline further''; and Lorine Pruette's collection of sensational ''modern portraits.'' These are little true vignettes, from which the author tentatively concludes that female initiative in sex is increasing; that old concepts, such as ''caddishness'' and the double standard, are invoked in time of trouble to ''proclaim that what is sauce for the goose is not sauce for the gander''; that ''actually, there is little respect anywhere for chastity''; that ''young women to-day appear to have a direct and definite desire for sexual experience''; that ''a new romanticism shows signs of developing''; and that ''the young people of to-day who are so eager to marry probably do not suspect that they are entering the most difficult and dangerous of all relationships.''

But there is one thing more. The insidious and sardonic Dr. Wile has the last word in the form of two pages of ''questions without answers.'' If, as he says, ''each unmarried adult who raises a personally centered question must answer it in terms of his own constitution, training, and experience,'' the fact remains that modern knowledge will help toward a safe and satisfactory decision.

Mrs. Bromley's book on birth control, introduced by Dr. Dickinson, needs no extended notice. It is the first and only book for the general public that is absolutely unexceptionable scientifically and is at the same time lively and intensely interesting to read. It illustrates Mr. Ernst's remarks on law very aptly, since it speaks boldly on every aspect of the subject, including details of contraceptive practice. ''Abstinence,'' says the author, ''jeopardizes marriage and may be the cause of impotence and nervous disorders''; the ''safe period'' has been an old wives' tale and is not scientifically reliable now; the advertised methods of ''feminine hygiene'' are highly questionable; abortion—when not made unnecessary by birth control or sterilization—should be legally in the hands of competent medical men. There are about 700,000 abortions performed each year in this country. With between 5,000 and 10,000 illegally done in New York City each year, there have been only two convictions in the courts in fourteen years. This is an example of Ernst's nullification. Sterilization without unsexing and pathological sterility are very fully discussed, as well as various proposals and possibilities for the future. ''Women to-day are evolving their own ethics, regardless of the dictates of either Church or State.'' And the scientific basis for this movement, visible throughout Mrs. Bromley's book, assures its success and marks the futility of opposition.

Niemoeller's encyclopedia is a strange production. It brings together in one alphabetic series a number of things listed as separate works on the title page, including a dictionary of sexology, a lexicon of medico-sexo-legal expressions, a list of scientific sex works, a manual of noted names in erotology, and so on. It is intended to define and

fix the meanings of words in the complex and copious language of sex so that the extensive literature of the subject may be intelligible to laymen, and also to communicate directly a great deal of information to readers who may be ignorant in this field, however well-informed otherwise. Most of the 4,000 statements are very short, mere definitions; but here and there a brief article is appended, the longest (on "postures, erotic") covering nearly two pages. The enterprising publishers have placed a number of advertisements on the front flyleaves and offer to furnish any book mentioned by the author; and yet neither this commercialism nor the author's tendency to have his little joke now and then should obscure the real merits of the work. A book that gives correctly the special usage of hundreds of common words and defines precisely a vast number of technical, literary, and historical words, names, and phrases must be gratefully accepted, even though it comes, perhaps, in somewhat questionable guise.

H. M. PARSHLEY.

Smith College.

SEX IN PRISON. By Joseph F. Fishman. New York: National Library Press, 1934. 256 p.

Mr. Fishman has been in prison work for the last twenty-five years. Formerly Inspector of Federal Prisons, in 1928 he became Associate Consultant in Delinquency and Penology of the Russell Sage Foundation, a position from which he resigned to become Deputy Commissioner of the New York City Department of Correction. This office he held until the beginning of the present régime. He has had close contact with American prisons and this book is an attempt to discuss frankly a subject that is of vital importance, and yet that until now has been shrouded in silence and entirely tabooed by prison officials. Dr. Harry Elmer Barnes, who is quoted in this volume, makes the statement: "If one were consciously to plan an institution perfectly designed to promote sexual degeneracy, he would create the modern prison." The reviewer, in his years of prison work, found that he was required to keep silent on sex subjects and to ignore its importance in the life of the average inmate, in spite of the fact that sex was ever brought to his attention in his routine psychiatric examinations.

Unfortunately, Mr. Fishman does not keep an entirely scientific outlook when discussing this problem, although he does present in a rather vivid and convincing manner the dire results of official unconcern. He points out that "the majority of prisoners spend at least four or five of their waking hours each day in small cells by themselves. If they do not have the ability or the application to

read, they must depend on their own thoughts to pass the time, and such thoughts must of sheer necessity take a pleasant turn in order to give them some relief from the monotony of prison life. This pleasant turn too frequently takes the form of phantasy and daydreaming about sex." Mr. Fishman then goes on to point out how many normal young men become degraded as a result of the abnormal environment found in prison, and eventually become homosexuals. He estimates that from 20 to 40 per cent of prison inmates are homosexuals, but further states: "For some reason physicians, psychiatrists, and others actively and passively engaged in prison work either ignore this important issue in full or in part. . . . Only those who have had long experience in prisons can understand the ethical code of the prisoners and the way in which this governs their conduct. This unremitting, unseen, and irresistible pressure functions all the time in prisons."

The author discusses at some length how the sex problem can be handled in prison. "Undoubtedly keeping the inmates . . . busy is of enormous value in helping to solve partially some of the problems, physical as well as mental. . . . Few, if any, of the large penitentiaries and reformatories have enough work to keep all able-bodied prisoners busy at the same time. . . . Exercise, of course, must play an important part in any system designed to keep prison inmates busy, . . . and suitable recreation."

In his last chapter the author discusses the question, "What can society do about sex in prison?" and argues in favor of allowing prisoners vacations in order that they may make a normal sex adjustment to life.

Unfortunately, Mr. Fishman has missed an excellent opportunity to present this subject fully and the reader feels rather let down at the end of the book, although the author should be given credit for having the courage of his convictions and presenting them to the public. His arguments are not likely to impress prison authorities, and there is little doubt that the smug indifference that has always characterized the majority of these keepers of mankind will continue in the rut that was begun in the Dark Ages.

J. L. McCartney.

Portland, Oregon.

Training in Psychiatric Social Work. By Sarah H. Swift. New York: The Commonwealth Fund, 1934. 177 p.

This small, ably written monograph, which made its appearance late in 1934, will find its best readers among certain specialists, notably student supervisors in social case-work agencies. As a review of the unique venture in student training at the Institute for Child

Guidance, New York City, between 1927 and 1933, it constitutes one of the very first published pronouncements on the problem of converting the untutored student into a finished case-worker. It purports to be narrative and descriptive, but the content lends itself most profitably to appraisal of method and should be helpful to many a troubled adviser on field work in laying plans which hitherto have had to be left far too often to chance and intuition. Particularly fruitful of such guidance are Chapters V, VI, and VII.

The book is not one, however, that need have a restricted public. The historical material of the first chapter cannot help but be of wide interest. For the statistically inclined, there are a number of intriguing tables suggestive of the correlation between age, length of experience, and ability to progress in training, and the volume as a whole can be said to have important implications for the broad field of social work and for psychiatry as well.

Without presuming to be authoritative, Miss Swift has succeeded in capturing the essentials of an exceptional experiment in human relationships and has presented them in a form calculated to serve the interests of a large professional group.

Winifred W. Arrington.

The National Committee for Mental Hygiene.

Wish-Hunting in the Unconscious. By Milton Harrington, M.D. New York: The Macmillan Company, 1934. 189 p.

This little book is a plain, outspoken criticism of the Freudian doctrines, frankly hostile in point of view and directly based both upon the writings of Freud and the author's experience with mental diseases. The philosophy that underlies the author's point of view may be called organic and philosophic, and the psychology of his approach is directed by his point of view.

The reviewer believes that Dr. Harrington has done a good job and one worth the doing. The quotations from Freud are authentic and further they are so grouped and arranged as to represent, not isolated Freudian doctrines, but what may be called a continuum of Freud. While the tone of the criticism is definitely hostile, it is at the same time respectful. It lacks the bitterness so often found in the anti-Freudian point of view, although Dr. Harrington is not above sly humor at times. The author is evidently a close student of the writings of Freud and he is wise enough to limit himself mainly to the master, as it may safely be said that Freud is not responsible for his disciples.

In the reviewer's opinion the book is very well worth reading both for Freudians and non-Freudians, but it is especially to be recommended for the layman who practically never gets a coherent account

of Freudianism. Most popular accounts of Freudian theories are definitely emasculated and the doctrines as they are presented are somewhat sugar-coated. This plain, unvarnished account will do much to enlighten the general lay and medical public as to the nature of Freudism and of the opposition to it.

ABRAHAM MYERSON.

Tufts College Medical School.

WHO SHALL SURVIVE? By J. L. Moreno, M.D. Washington, D. C.: Nervous and Mental Disease Publishing Company, 1934. 440 p.

In this book, Dr. Moreno has postulated a basic concept of integration and dynamic evolution for any community group and has proceeded to construct methods for studying and depicting this integration and biological change. The greater part of the book is devoted to this methodology, although Dr. Moreno indulges somewhat also in interpretation and prospecting. The whole presentation is refreshing because of its spirit of freedom from traditional method and at the same time for the fact that it uses common-sense approaches to values and erects these into more formal and repeatable procedures. It is very easy to disagree here and there with the author and to point out gaps and inadequacies, but one must realize that this would merely be saying that there still remains much to be done, and the same can be said of every live science. It is a credit to Dr. Moreno that one sees more to be done after his presentation than one did before.

Specifically, his method is to show graphically and descriptively the relationships between members of groups by formal testing procedures. In the classroom, the child is asked to select those whom he would choose to have sit beside him. In the institution for delinquent girls, each is given the opportunity to choose those girls with whom she would like to live and the house mothers are given a similar opportunity. Likewise, each is given the chance to reject certain members of the groups and in between to show indifference. This is Moreno's sociometric test. He offers this as a foundation for organizing the community in a way that will enhance its value to individual members. His acquaintance test is designed to bring out the range of any individual in the group and is used to show the changes that time makes in this range. In the spontaneity test, he brings individuals into contact with one another in order that they may dramatize certain attitudes extemporaneously in what is superficially a make-believe scene. The verbatim responses during this scene are analyzed for their latent meanings.

In the parent and family tests, the individual is subjected to those in authority and those with whom he will have to associate on an

equal basis, in order to get their reactions to him and his to them, as a foundation for assigning individuals to groups. Suggestions are made for the use of this in foster-home placement of children and the organization of new communities where migration occurs *en masse*.

The author is rather free in his use of analogies in the field of physics in a way that often confuses his meaning, and there is too much tendency to use new terms or old terms with new meanings. It is sometimes difficult to follow text and charts together because of disagreements due to poor editing. On the whole, however, these are relatively minor points compared to the positive values of the book.

GEORGE S. STEVENSON.

The National Committee for Mental Hygiene.

THE ORGANISM OF THE MIND; AN INTRODUCTION TO ANALYTICAL PSYCHOTHERAPY. By Gustav Richard Heyer, M.D. Translated by Eden and Cedar Paul. New York: Harcourt, Brace, and Company, 1934. 271 p.

In this volume Dr. Heyer has elaborated and presented a series of lectures designed to indicate the meaning of psychotherapy, to indicate why and how it is practiced, and to point out some specific psychotherapeutic ideas. The book is divided into two sections, the first dealing with organ neuroses and vital cycles, the second with analytical methods of treatment.

By organ neuroses Dr. Heyer means psychogenic disturbances that involve the impairment of bodily functions. In his approach to therapeutic methods, he aims to present the fundamentals of the being, the becoming, and the transformations of mental life.

He places special emphasis upon vital cycles. The cycle of nutrition includes all forms of gastric activity, the vomiting of pregnancy, intestinal inactivity, and similar disturbances due to failure to attain harmony with the vegetative world.

The animal vital cycle of circulation concerns itself with the heart; the pneumatic vital cycle of the respiration deals with breathing, the breath, and the spirit; the mental vital cycle involves the influence of mind upon the body and points the way to treatment by suggestion, with due consideration for man's will, his susceptibility to persuasion and suggestion.

Dr. Heyer deems the blood to be the dynamic carrier of vital movement. Hence he stresses the meaning of cardiac neurosis and the relation of anxiety to anginal pain. He emphasizes the value of massage, particularly nerve-point massage for asthmatic and gastric disorders, while he expatiates upon the relation of heart symptoms to mental experience. In his discussion he rejects the Freudian sex concept as the fulcrum of life and discards the Adlerian will-to-power,

because he believes "we are at odds with the animal in us" and the blood represents that animal life.

In some instances he has obviously written for the lay group, as indicated by the detailed manner in which he describes simple procedures. In other instances he dwells upon technical data in terms that are vague and uncertain even for physicians.

Discussing infantile trauma, he maintains that in the psychological domain "no event can be all cause *per se*, but only through its reactions upon the mental life of a human being predisposed to act in a particular way." He distinguishes between neuroses that are conditioned and those that are in a sense iatrogenic. He is undoubtedly correct in refusing to confuse eroticism with sexuality, but less obviously so in asserting that all our nutritive processes involve a struggle between the eater and the eaten.

The pneumatic cycle provides the basis of a discussion concerning the phenomena of tension in breathing and relaxation. Breath kinship is recognized as related to our ethereal nature, though interconnected with our "lower" nature. The "Yoga" exercises are regarded as regulating expiration and as raising the depth of the unconscious to easier conscious access. By breathing exercises one can get in touch with the spiritual elements of life and engender a "divine" tranquillity.

The fourth vital cycle is the psychophysical one in which we are factors that involve the organization of the spiritual qualities of life. Man in a sense harks back to the function of the leader, and perhaps, as the author suggests, man finds himself less inclined than of yore to seek the Spirit in external forms, but rather to search for it in his own breast. In the pursuit of this spirit, psychoanalysis becomes even more valuable than ordinary suggestive therapeutics because conscious powers or will are futile. In the development of this concept, psychoanalysis is held to have originated for moral as well as medical reasons.

Throughout one finds a mixture of philosophy and religion in which mysticism is admitted and defended. The emphasis upon thoroughness in analysis is found to rest upon the rejection of Freudian and Adlerian concepts. During the at times confused discussion of the psychotherapeutic technics of the various schools of psychotherapy, Heyer makes it quite clear that he has achieved his greatest satisfactions in the complete acceptance and utilization of the principles and practices of Jung. He gives a general implication of the value of maintaining an eclectic attitude and of utilizing whatever appears to be adequate, satisfactory, and helpful in every school of psychiatric thought, although he definitely finds but little to employ outside of Jung's ideas. He gently suggests that in America there is a strong

tendency among therapists for each to employ the special school of therapy that emphasizes his own needs.

Dr. Heyer rises superior to Freud and Adler in so far as he believes that he approves the Jungian concepts because they are richer in spiritual motivation. Thus, although frequently moving with uncertain steps, he announces with finality, "We have reached our goal," which merely means that to him analytical psychology has become a truly spiritual movement, and therefore superior to the sexual analysis of Freud and the communal bias of Adler.

The book concludes with a series of plates which are allegedly reproductions of pictures drawn from the unconscious of analyzed subjects. These drawings, which represent automatic expressions, are interpreted on the basis of Jung's symbolisms, whose validity is unquestioned by those who accept the particular theory or doctrine that gives rise to the interpretative concepts of Jungian symbolisms. Eclecticism is manifest in the interpretation of the data because the author feels himself happiest in his far-flung Jungian collective unconscious.

IRA S. WILE.

New York City.

HEREDITY AND DISEASE. By Otto Mohr. New York: W. W. Norton and Company, 1934. 253 p.

This book, by a professor of medicine in the University of Oslo, formerly professor of anatomy there, and one-time student of genetics under Prof. T. H. Morgan, deals with the topic of human genetics with special reference to disease and defect. As he has already contributed some important researches in this field, Dr. Mohr is particularly well qualified for writing this book.

After a discussion of cells, chromosomes, and the mechanism of sex determination, he devotes a long chapter to the theory of genes and the rôle of chromosomes in heredity, with special reference to human traits. An equally large section of the book is devoted to representative cases of hereditary diseases in man, to lethal genes, twins, and the inheritance of traits that have been specially studied, such as those relating to alcohol and cancer. Finally, he makes certain applications of these principles to intermarriage, degeneration, aristogenesis, sterilization, birth control, *et al.*

The book is well illustrated by 45 line drawings and pedigree charts in the text and by 16 half-tone plates, presenting mostly particular mutations. It is well and clearly written and shows a command of the English language that is rather surprising in a lifelong resident of Norway.

The author properly devotes a good deal of space to the fruit flies,

upon which many modern genetical principles are based. His many complicated points are elucidated by useful diagrams. In the work of so experienced a geneticist, there are few statements to which one can take exception. Perhaps the author develops too much the contrast between heredity and environment, although he does devote a paragraph to the interaction of genes and environment. He may also be thought to have laid too much stress upon the genes, to the neglect of the cytoplasm, but this is a fault found in most modern genetical works.

Altogether, the book is to be highly recommended to medical men and to others who want a readable text on genetics as applied to humans.

C. B. Davenport.

Carnegie Institution of Washington.

Child Psychology. By George D. Stoddard and Beth L. Wellman. New York: The Macmillan Company, 1934. 419 p.

Here is a book in which the authors have assembled many, if not all, of the more important results of research in the field of child psychology and presented them as a basis for the study of the child.

The book is divided into four parts. Part I—*Introduction to the Field*—covers trends in child psychology and methods of research. Part II—*Motor and Mental Development*—deals, in separate chapters, with motor development, sensory discrimination, concepts and thinking, language, growth of intelligence, intelligence as related to other factors in child development, the measuring of intelligence, and learning. Part III discusses the topics of social behavior, play, and the development of artistic capacity. And Part IV takes up research in emotional patterns, personality and behavior aberrations, character, and the meaning of personality.

The material is very well organized and documented. Controversial topics are presented from several points of view, and the authors are unusually objective in their comments and interpretations. There is a bibliography of 493 carefully catalogued references, an index of authors, and a good subject index.

In the opinion of the reviewer, this is a valuable contribution. It makes a wealth of information easily accessible and it is presented in a form and manner that should appeal to the experienced worker and the advanced student of child psychology. It may be used profitably as a source of original information, a reference book, or an advanced text, as it offers many well-considered suggestions for further study and research.

Frederick W. Brown.

Garden City, New York.

AN INTRODUCTION TO APPLIED PSYCHOLOGY. By Coleman R. Griffith. New York: The Macmillan Company, 1934. 679 p.

Dr. Griffith has been especially known for his studies regarding psychology in athletics, which have their due place in this volume. The table of contents reveals a breadth of view probably not surpassed in any psychological volume by a single author, and the even level of merit sustained over such diverse fields is a notable accomplishment. Thorough treatments will hardly be expected, and it is a frequent experience to feel that the author is getting off to a good start on his chapter only to find the next page bringing a conclusion. But "she'll vish there wos more, and that's the great art o' letter-writing." The absence of graphs, tables, and illustrative matter of all sorts is probably a sacrifice, and quantitation generally is not stressed.

The merits of the volume as a teaching text are that it lays a foundation on which the teacher of original mind can build his further ideas, or, from a more elementary standpoint, leave fairly accomplished the object as Dr. Griffith states it, that the student "knows something about the domain of applied psychology and at the same time . . . has caught a glimpse of what it means to take a scientific point of view towards the study of human nature."

This should not be understood as blanket endorsement of content detail. Perfect score in accuracy cannot be given to one who writes that schizophrenia "often goes by the name dementia praecox" (p. 312)—still worse, that paranoia "is, perhaps, the most frequent type of psychosis" (p. 313). Neither did the reviewer ever write a book called *Mental Tests in Criminal Practice* (p. 239), but we thank him "for the compliment just the same."

F. L. WELLS.

Boston Psychopathic Hospital.

NOTES AND COMMENTS

Compiled by
PAUL O. KOMORA
The National Committee for Mental Hygiene

FEDERAL GOVERNMENT OPENS FIRST NARCOTIC FARM

The first United States Narcotic Farm, established at Lexington, Kentucky, was formally dedicated and opened by the Surgeon General of the Public Health Service, Dr. H. S. Cumming, on May 25. This unique institution, built by the Federal Government at a cost of $4,000,000, with a capacity of 1,000 beds and a staff of 245 employees, will care for more than half of the approximately 1,800 narcotic-drug addicts in Federal prisons throughout the country. A second institution will be established later at Fort Worth, Texas.

The Lexington institution, which is designed primarily for the care of the more intractable prisoner type of patient, though it will also take voluntary patients, represents a definite change in the government's policy toward the country's drug-addiction problem. According to the official announcement, no person will be eligible for treatment unless he is an addict as defined in the law authorizing these narcotic farms, and then only if he complies with the regulations governing admissions. Under these regulations the following four types of patients will be admitted:

1. Persons sentenced to confinement upon conviction of an offense against the government.
2. Persons who, upon the completion of a sentence of confinement at the narcotic farm, apply for further custodial care beyond the expiration of sentence.
3. Persons placed on probation by any court of the United States or other Federal authority which has imposed as one of the conditions of such probation that they submit themselves for treatment until discharged as cured.
4. Persons who voluntarily sign applications requesting custodial care and treatment.

Experience shows that there are certain groups of addicts who require close supervision, while others may be benefited by a more liberal policy. For that reason the custodial features have been emphasized in the Lexington plan, whereas the institution at Fort Worth, where the cottage plan will be adopted, will be more open in character and will care for patients who can be allowed a greater

measure of freedom. The establishment of these institutions is the result of the government's realization, after long experiment and observation, of the fact that confinement with hardened criminals of persons afflicted with an unfortunate habit is a policy that results in the degradation of the addicts until they themselves become criminals. It is also a recognition of the fact that a cure of the merely physical craving for a drug is not a cure of the habit—that the mental habit and the causes underlying it are far stronger than had heretofore been believed.

Consequently, the narcotic farm at Lexington has been instituted as a long-term experiment in the mental and moral, as well as physical, rehabilitation of the addict. Based upon a realization of the need for the threefold aspects of rehabilitation, the hospital has been planned and erected with meticulous attention to all the details involved in equipping the addict to resume a normal and useful place in life.

In addition, the control, management, and discipline are to be maintained for the safekeeping of the individual and the protection of American communities. Shops are being established to afford occupation, vocational training, and education. Experiments are to be carried on to determine the best methods of treatment and research in this field, and the results are to be disseminated to the medical profession and the general public. The project has been interpreted by the Public Health Service as a form of specialization bearing a direct relationship to policies of law enforcement, to special problems in penal and correctional procedure, to the safeguarding of the uses of narcotic drugs in medical practice, and to the quest for more accurate and fundamental knowledge concerning the nature of drug addiction and related phenomena. In short, the functions of the institution will assume the character of a treatment and research center and of an educational, industrial, vocational, and rehabilitation center, with certain custodial features superimposed. Dr. Lawrence Kolb, senior surgeon of the United States Public Health Service and an experienced psychiatrist who has for many years specialized in the study of drug addiction, is the chief medical officer in charge of the hospital.

Students of the problem will be interested in the following interpretation of the policy and program back of this significant endeavor as defined by Dr. W. L. Treadway, Assistant Surgeon General in charge of the Public Health Service's Division of Mental Hygiene:

> "The problem of institutional treatment for drug addiction must take into account not only the precipitating causes of addiction, but the diverse motives of those seeking treatment, the incidence of intercurrent diseases and defects in such a group, the great differences in

the types of personalities involved, and the need for protecting the institution community against the weaknesses and cupidity of its component individuals. The immediate causes of addiction are related to the previous uses of such drugs in medical treatment, to self-treatment for the relief of pain, to recourse to drugs during emotional stress, to the influence of and association with others who are habituated to their uses, and to indulgence for the sake of experience, curiosity, bravado, or just for 'the thrill of it.'

"The more important predisposing or underlying causes of addiction are related to the inherent constitutional make-up of the individual. The so-called nervously unstable person is more prone to embrace the habitual use of narcotic drugs than one with a stable constitution. Experience with persons addicted to the use of habit-forming drugs indicates that they have had many emotional difficulties and inner conflicts long before they became addicted, and the fundamental factors in the treatment and rehabilitation of such persons are a definite challenge to psychobiology and necessitate an appreciation of the mental-hygiene factors involved.

"The problem of the treatment of drug addiction in its present stage involves a pharmacological, biochemical, psychological, and medical approach. The fact that an individual, through long use of opium or its derivatives, may safely take large doses of his drug that would be fatal to one unaccustomed to their use, has intrigued the interest of many observers. It has been explained on the grounds that the oxidation of morphine within the body produces a toxic by-product that is neutralized by an additional intake of morphine, and unless so neutralized, gives rise to abstinence symptoms. This theory, together with that of a supposed development of active immunity from the use of such drugs, is of historical interest only. Other hypotheses deal with the fate of morphine in the human body. These hinge upon the theory that the rate of destruction is increased through habituation; that muscle tissue acting as a buffer develops the power to store morphine and to release it so gradually as not to affect the nervous system fatally; that body cells, particularly nerve cells, are rendered less sensitive through continued use of the drug; and that the glycerophosphoric or cholin lecithin portion of the cell molecules is replaced by the alkaloids. A great deal of study will be required, however, before these hypotheses can be firmly established.

"The inception of the institution at Lexington is based on the belief of the United States Government that restrictive laws governing commerce in narcotics are not the only measures to be applied as a possible solution of the medico-social problem of drug addiction. The presence in American communities of persons who are addicted to the use of narcotic drugs constitutes an ultimate market for smuggled or contraband drugs, and tends to menace the legal supply of such drugs originally destined for medical or scientific purposes. Public policy, therefore, which has for its object the regulation and control of the production and distribution of narcotic drugs is effective only in so far as it undertakes to control, segregate, or cure the drug-addict population of a community.

"The isolation and segregation of drug addicts for the purposes of medical treatment, therefore, appears desirable and necessary, for their

presence and contact with others in American communities are a potential danger and a causative factor in the production of further addiction, it being estimated that more than half of the present-day addiction is attributable to contact with other addicts.

"The significance of legislation in relation to Federal offenders may be better appreciated when it is realized that repeated prison sentences have been imposed more often upon drug addicts than on any other type of adult prisoner. The situation respecting repeated prison sentences has challenged the usefulness of the method of handling drug addicts through prison sentence alone. An appraisal of this new policy respecting the establishment of the narcotic farms may be best made through study and investigation of the problem of drug addiction as it affects the population as a whole. Such studies have shown that addiction to habit-forming drugs is widespread; that all classes and groups of the general population are affected in one way or another; that the geographical distribution of these people corresponds relatively to the geographical distribution and density of the general population; and that occupation, age periods of life, nativity, sex, color, marital, and educational status are contributory factors.

"Heretofore, so far as public policies are concerned, drug addiction has been regarded almost solely as a penal and correctional problem, somewhat like that of the insane of an earlier day. With the establishment of an institution such as that at Lexington, it is now appreciated that any betterment in the social, moral, and economic conduct of a self-governing people springs not from the mind of any one person or group, but from the congregate opinions and wishes of the entire community."

Ninety-First Meeting of the American Psychiatric Association

Urging that the American Psychiatric Association take the leadership in formulating means to combat the ever-increasing population in hospitals for mental disease, Dr. C. F. Williams, Superintendent of the South Carolina State Hospital, speaking as president of the association at its Ninety-first Annual Meeting in Washington, D. C., on May 14, said that the time was rapidly approaching when some substitute or supplementary measures would have to be devised for the permanent institutional care of the mentally ill.

"Through the awakening of the public consciousness as a result of the advance in many phases of psychiatric activity," Dr. Williams said, "there is a growing conviction that institutional provision alone is an inefficient, unwise, and uneconomic method of meeting the problem of mental illness, and that for too long we have been dealing with end products and have not given adequate attention to the supply at the source." He declared that the underlying causes of mental sickness must be sought out and removed and that the mentally sick must be recognized early and given adequate treatment, so that they may be cured or aided in their adjustments and not become charges on the community or the state.

As a phase of a definite program toward this end, Dr. Williams asked that mental hospitals "be more universally used as teaching centers for medical students and physicians," and that there be increasing emphasis on research and experimentation. In this connection he pointed out that the clinical physician must acquire a better understanding of the importance of emotional and environmental factors in health and disease, while at the same time psychiatrists should adopt more of the conservative, laboratory-minded attitude of the trained clinician. While the tendency among psychiatrists to stress environmental factors has perhaps annoyed the clinicians as much as the latters' emphasis upon chemistry, physics, and biology has irritated the psychiatrists, he urged that each group partake of the attitude of the other and thus hasten the day when the gap between psychiatry and general medicine, happily becoming narrower every year, may be entirely closed. Dr. Williams also recommended that in the future programs of the association more time be allotted to papers dealing with the broader social aspects of psychiatry, stating that this "administrative phase" of psychiatry has been neglected in the past, and that the changing social order and the need for preventive psychiatry make it important that this field be covered more fully at future meetings.

The public-relations problem of psychiatry and mental hygiene was discussed from different angles in two interesting papers by Dr. Lloyd H. Ziegler, of Albany, New York, and Dr. Charles A. Rymer, of Denver, Colorado. Dr. Rymer deplored the exploitation of the suffering public by "practical psychologists," cultists, faddists, quacks, and charlatans who undertake to relieve neurotics, the inadequate, inferior, and insecure of their difficulties, as well as their money, and lead them into the promised land of happy adjustment. Among the pernicious results of the activities of these "practitioners" of the healing arts, he cited as particularly detrimental the dangerous falsification and distortion of health facts and the misleading and unscientific nature of their material; the false sense of security and the spurious hope of relief engendered by their artificial and meretricious remedies; and the doubts and suspicions they arouse in their patients with regard to the ability and knowledge of the legitimate medical profession.

To combat the influence of these traders on the gullible public, Dr. Rymer offered three suggestions: sound public instruction in the fundamentals of physical and mental health, under the ægis of state and county medical societies and through the educational programs of mental-hygiene agencies, parent-teacher associations, and other similar organizations; the establishment in every city of a board of physicians to examine the credentials of health lecturers;

and an investigation by the American Psychiatric Association into the whole question of psychological quackery, leading to the development of a program calculated to deal effectively with it.

Dr. Ziegler's paper brought out what is undoubtedly a contributory factor in the prevalence of quackery at the present time—namely, the widespread misinformation and the many misconceptions that still prevail in the public mind with regard to mental and nervous disorders.

As an example of such misconceptions, Dr. Ziegler cited the common notion which associates mental illness with manifestations of violence, as disclosed by an inquiry among one hundred lay people with regard to their ideas about the symptoms of common diseases. It should be pointed out, he said, that contrary to the popular belief, the insane are not "violent, homicidal, and treacherous persons"; apathy and indifference, especially in caring for themselves, are the symptoms most frequently encountered among them.

In contrast to this misconception of mental disorders on the part of the public, Dr. Ziegler found that, "due perhaps to the widespread educational campaign" of public-health organizations, a surprisingly large number of people were fully cognizant of the symptoms and treatment of tuberculosis. Concerning heart disease and cancer, however, there is the same widespread misinformation and lack of knowledge as in the field of mental disease. In stressing the importance of continued public education with regard to the causes, symptoms, and prognosis of mental illness, he warned that "incomplete or false concepts may be the basis of inadequate protection to a person with the symptoms and signs of serious disease and may be the basis for psychogenic vulnerability under certain circumstances and to certain individuals."

Language as a factor in the problems discussed in the foregoing papers was suggested by an illuminating study of the lingual output of psychotic patients, presented by Dr. William L. Woods, of the Iowa Psychopathic Hospital, Iowa City. While confined to the use of language among the abnormal, his findings offered a fertile and tempting source of speculation with regard to their implications for the normal. On the one hand, there is the not inconsiderable influence exerted by the quack's glib manipulation of a high-sounding technical vocabulary which impresses his dupes and lends an air of authority to his "counsels." On the other hand, there is the problem of clear and simple interpretation of the teachings and principles of psychiatry and mental hygiene which are largely shrouded in an obscure and abstruse terminology not intelligible to the masses and making for much of the misinformation, ignorance, and superstitions regarding mental disease still prevalent in the public mind.

Whether they justify the cynic, who said that language was invented to conceal thought, or whether they illustrate the adage that the insane are pretty much like the rest of us, only more so, Dr. Woods' discoveries serve to emphasize the importance of plain speaking in relation to straight thinking in educational work in our field.

Dr. Woods found, after a prolonged study of the conversations of one hundred psychotic patients, that while they revert to simpler, infantile modes of thought, they retain adult language structures, the result being a disparity between formal language and order of thought. He explained their apparent facility of speech as follows: "Glibness which comes from reservation of deeply ingrained speech disguises the underlying defects. Furthermore, a facility with words, which is disproportionate to clarity of thought, provides an escape from exactitude in empty mouthings." An examination of numerous verbatim reports of the conversational output of these patients showed "either acute states of hopeless striving for expression, or states with duller affect where the individual has been content to follow the line of least resistance." Then there are groups with "livelier affect" who present a different picture where there is a more facile and productive flow of language, and where "one is bewildered by the elaborate word structure, the bizarre descriptions, and the abundance of high-sounding phrases." There was nothing in his findings, he said, to suggest that schizophrenic speech disturbance is intrinsic in the speech faculty or is at all comparable to aphasia. The fault is not at a verbal level; on the contrary, there is a disproportionate facility with words in comparison to thought, tending to show that language changes are intimately bound up with an alteration in thought processes.

The program, as usual, included many reports of original researches and studies dealing with various aspects of the mental-disease problem. Much of the material presented reflected the slow, but steady advance that psychiatry and its supporting sciences are progressively making toward a better understanding of the problem and the development of more effective procedures for coping with it. On the other hand, as an illustration of this progress in its negative form, more than one paper showed the need for revising concepts that may have had a certain usefulness in the past, but are now seen to be retarding further advancement in the clarification of psychiatric issues. In a paper on the relation of trauma to mental disease, for example, Dr. Abraham Myerson, of Boston, challenged the evidence thus far presented that environmental conditions "had anything to do" with the inception of dementia praecox or manic-depressive psychoses. Inclining to the view that they are due to hereditary and constitutional causes, he declared that the assump-

tion that an external event may precipitate either or both of these types of mental disease is at least "in question," and cited several cases in which slight physical injury was sustained by the patient, with the development of mental illness some time later, to show the "unreasonableness" of such an assumption. He admitted some relationship, if an event of a serious nature and of great emotional significance occurred and the mental illness followed in a very short period of time, but held that this applied only to manic-depressive cases. Under no circumstances would he concede any relationship between trauma and dementia praecox, which, according to Dr. Myerson, is not emotional in its origin. He brought out the significance and importance of this question of the relationship of physical injuries to subsequent mental disease in relation to the law courts and current practices with regard to expert testimony in cases of this type, which were "disastrous to justice and to the prestige of psychiatry and psychiatrists."

The deflating, but salutary effect of the newer findings in criminological psychiatry was illustrated in a frank paper by Dr. Max Winsor, of the New York State Training School for Boys at Warwick, New York, who analyzed the scope, limitations, and possibilities of psychiatric practice in institutions for delinquents.

Conceding that psychiatry had not made much headway in most penal systems, and that the public had, perhaps, been led to regard it as a panacea, Dr. Winsor pointed out that in many cases the attitude of penal authorities toward psychiatry was one of indifference or open hostility, and this—combined with the fact that psychiatric personnel were unable to do more than scratch the surface because of multitudinous duties—made progress exceedingly difficult.

"Psychiatry has not been altogether effective because much of its energy was frittered away," Dr. Winsor said. "Psychiatry, we believe, was brought into penal institutions on wrong assumptions. The issue was made that there were so many undiagnosed psychotics and extreme neurotics in the prison population that there was need above all for diagnosis of these cases. We believe there was so much emphasis on diagnosis that there was no time for treatment, so much demand for pathology that there was no time or energy left for hygiene."

Instead of spending so much time and energy on routine diagnosis, Dr. Winsor advocated a treatment program for the entire institution, resulting in the education of the personnel for collaboration with the psychiatrist, so that "a psychiatric atmosphere permeates the institution as a whole." Under lay administration this becomes a task of grave proportions because of a lack of understanding and sympathetic support. He would, therefore, have psychiatrists

assume a more active rôle in the direction of policies and the inauguration of psychiatric facilities within the prison, with the ultimate aim of operating the prison on somewhat the same basis as a hospital and of individualizing the prisoner's treatment according to case-history data, carefully and accurately compiled.

Institutions, like other social structures, develop historically rather than logically, Dr. Winsor pointed out. Science may enter one wing of the prison, but remnants of the dark ages remain as a "hold-over" in other parts of the institution. "The modern institution," he said, "must change throughout to be capable of its responsibility as conceived to-day. If we grant that delinquency and crime are not to be explained by a single causative factor, we should expect that treatment will be as complex as causation and the institution will have to provide the multiple means for dealing with these multiple factors. We suggest that the psychiatrist be given a prominent rôle in the integration of these complex units of diagnosis and treatment. . . . We believe that the integration of the various facilities in line with general mental-hygiene principles has a greater call on the psychiatrist's time than specific psychiatric examination." The burden of proof is on psychiatry, he concluded, to demonstrate that there is reality in mental hygiene and effectiveness in the technique of psychiatry.

The following officers were elected for the ensuing year: *President:* Dr. Clarence O. Cheney, Director, New York State Psychiatric Institute and Hospital, New York City; *President-Elect:* Dr. C. Macfie Campbell, Director, Boston Psychopathic Hospital, Boston, Massachusetts; and *Secretary-Treasurer:* Dr. William C. Sandy, Director, Bureau of Mental Health, Harrisburg, Pennsylvania. The next annual meeting will be held in St. Louis, Missouri.

Washington Institute Holds Second Annual Mental-Health Conference

The Washington Institute of Mental Hygiene held its Second Annual Conference in the District of Columbia on May 23–24, under the sponsorship of sixteen different educational, religious, health, and social-work organizations of the district. The institute—of which Dr. William A. White is president and Dr. Paul J. Ewerhardt, director—conducts the Washington Child Guidance Clinic at the Polk School and Children's Hospital and the Washington Life Adjustment Center, a mental-hygiene clinic for adults.

The conference took up such topics as unemployed time as a challenge to mental hygiene, problems of adult education related to life adjustment, the rôle of special interests in children's recreation, the

emotional hazards to children of certain types of radio programs, and the effects of the economic depression on the mental health of children. Joint sessions and section meetings were also held for teachers, nurses, and social workers.

In his opening talk on "Mental Hygiene and Present-day Problems," Dr. White developed the evolutionary concept of man's understanding of the problems that beset the individual in his adjustment to modern life. In early times, he said, any misfortune was attributed to "nature and magic." In his evolution man gradually began to develop the idea of a more intelligent cause and effect. On this basis he began to relate certain conditions that affected him to certain alleged causes. This was the era when, with insufficient understanding, only immediate causes were discerned. Remote and belated causes had not yet been included in the understanding of final effects. In our present-day attitude we try not to relate effect with a particular cause, but rather to understand the final effect in terms of many antecedent ideas, thoughts, experiences, satisfactions, and so forth, all related, one to the other, in bringing about the end result. In discussing mental hygiene in terms of this latter notion, Dr. White expressed the hope that the attempt to comprehend the lengthy chain of experiences of the individual, which are put together and reacted to by the specific organism with its own heritage and background, would give the necessary clues to the establishment of correct insights into human behavior.

Dr. Frederick H. Allen, Director of the Philadelphia Child Guidance Clinic, spoke briefly on the effects of the economic depression upon the behavior of children and young people, observing, cautiously, that although they may not always be demonstrable, "some effects must have been produced." He alluded to vague insecurities which the child may gather up from an insecure environment, as well as from adults whose morale may have suffered too great a challenge. He discussed the problem of how a client may be helped by the specialist to achieve a greater inner security. A specialist, whether doctor or social worker, cannot *give* any one security; all he can do is to *assist* the person in obtaining it. Therefore attention should be directed to the understanding that is required of a person before this goal can be reached.

The mental-hygiene aspects of the recreation of children were discussed by the Reverend Paul Hanly Furfey, Associate Professor of Sociology of the Catholic University of America, Washington. We are keenly aware of the importance of individual differences in our educational and clinical treatment of the child, but in organized recreation, he pointed out, we often lose sight of this important principle. This is unfortunate, Dr. Furfey said, "for studies of play

activities have clearly shown that individual children differ strikingly in their play life. Some of these individual differences are normal, while others may be considered pathological." Among the latter he mentioned (1) a general quantitative deficiency in the play life; (2) a specialized deficiency in some department of play, for example, a lack of active play; and (3) the presence of pathological forms of play.

Among the causes for these variations, Dr. Furfey cited abnormally high or low intelligence, differences in socio-economic class, play facilities or the lack of them at home and in the neighborhood, and many other factors. A particularly interesting set of causes, he said, was revealed in a series of studies of nursery-school children carried out by Miss Deborah Quinlan, a student of the Catholic University, at the National Child Research Center. Miss Quinlan's findings emphasized the importance of speech defects, parental fixations, lack of early contacts with other children, and unpleasant early contacts with other children as factors in the meager recreational life found in some of these children.

As a remedy for these conditions, two things were suggested: (1) a greater awareness on the part of parents and teachers of the importance of a well-balanced recreational life in the development of the child, and (2) the provision of a larger number of trained recreational leaders in order that the child may receive the individual attention he needs in clubs and on playgrounds.

State Society Notes

Connecticut

The Connecticut Society for Mental Hygiene held its Twenty-seventh Annual Meeting on May 20 in Bridgeport, in conjunction with the Eleventh Annual Meeting of the Bridgeport Society for Mental Hygiene. Following the business meetings of the two societies, and an informal dinner at which Dr. E. Van Norman Emery and Dr. George K. Pratt, the medical directors of these organizations, presented reports on the year's activities, a joint session was held at which Homer Folks, of the New York State Charities Association, and Dr. Clarence M. Hincks, of The National Committee for Mental Hygiene, were the principal speakers.

Expressing confidence in an early recovery from the depression in morale, ambition, interest, and zest for living, Mr. Folks discounted the supposedly disastrous effects of the economic crisis on physical and mental health. He pointed out, for example, that only a small percentage of the increase in admissions to mental hospitals during the last five years could properly be attributed to economic factors,

and that the death rate from tuberculosis, which was expected to register promptly and seriously the effects of the depression, has, to the relief and surprise of health authorities, continued to drop about as rapidly as in the pre-depression years. Even the suicide rate, contrary to the general impression, has showed no significant correlation with business decline. While it showed an alarming growth up to and including 1932, from that year to 1935 there was an astonishingly abrupt drop back to the level of 1926.

On the other hand, taking issue with those who said that the depression was fundamentally a good thing for the people, Mr. Folks drew a melancholy picture of the general lack of confidence, initiative, and other constructive qualities vital to effective living characterizing not only that part of the population—one-sixth—which has been on relief, but also the other five-sixths who have been subjected to anxieties, fears, and other emotional strains deleterious to personal adjustment. In the case of the unemployed, of course, with their morale-impairing dependence upon relief, these hazards to mental health have been magnified a hundredfold, resulting in mental and emotional maladjustments and pathological reactions of varying degrees, short of actual breakdown. Nevertheless, it was his belief that as jobs become available, those who have been living on relief will "shake off their fears and give a good account of themselves and promptly return to the lists of those who do more than pull their own weight in the boat."

Dr. Hincks discussed some of the problems and difficulties facing mental hospitals in these trying times as a result of widespread budget cutting and the inability of institutional administrators to provide for the normal expansion of their facilities. Their struggle to maintain standards has been intensified by the recurrence of overcrowding, which in many institutions is so acute as to make it necessary to refuse new admissions. Recent reports from 34 states disclose an actual shortage of some 74,000 beds.

In this connection, Dr. Emery, in his report, brought out the extreme inadequacy of conditions in Connecticut, where intensive efforts are now being made to establish a second institution for mental defectives, to increase and improve the accommodations for the mentally ill, to raise the per capita appropriations for maintenance, and to provide a new system of centralized administration and integrated planning to meet the state's mental-health needs.

Missouri

The Missouri Society for Mental Hygiene held its annual mental-health conference in St. Louis on March 26–28. Backed by the local authorities headed by the mayor, who proclaimed the week of March

24 as "Mental Health Week," the event aroused more than ordinary public interest and was attended by many hundreds of person prominent in the professional, business, and social life of the city and state. Nationally known speakers addressed the various meetings, among them Dr. John J. B. Morgan, of Northwestern University; Dr. H. Douglas Singer, of the University of Illinois; Clifford Shaw, of the Chicago Institute for Juvenile Research; and Dr. Clarence M. Hincks, of The National Committee for Mental Hygiene.

Many topics were discussed, but special attention was centered on the institutional and community needs to which the Missouri Society has been giving increasing emphasis in its educational and promotional work during the past year. "The application of informed intelligence to the community problem of mental health" is the keynote of its program, which includes, among others, the following more urgent objectives: (1) a state mental-hygiene department or a mental-hygiene division in a reorganized state department of public welfare; (2) a psychopathic hospital for St. Louis—adequately staffed as well as housed; (3) a training school for defective colored children; (4) marked improvements in the mental-disease institutions—improved personnel and services as well as facilities; (5) a community mental-hygiene clinic, free from politics and "really having the kind of staff that is indicated by the name—that is, well-trained psychiatrists, psychologists, and psychiatric social workers experienced in child-guidance work"; (6) mental-hygiene services in the schools; (7) special psychiatric and psychological services in the juvenile court and the court of domestic relations; and (8) mental-hygiene services in the criminal courts.

The following officers were elected for 1935–1936: *President,* Dr. Paul Zentay; *First Vice-President,* Dean Sidney Sweet; *Second Vice-President,* Miss Nancy B. Johnston; *Third Vice-President,* Mr. G. Alex Hope; *Treasurer,* A. O. Wilson; *Secretary,* A. W. Jones.

North Carolina

A mental-hygiene institute, sponsored by the Mental Hygiene Society of Charlotte, North Carolina, was conducted in that city on May 24. The institutional shortcomings of the state, the place of mental hygiene in social work, child guidance, and other practical applications of mental hygiene, were among the topics discussed. The principal speakers were Prof. Howard Jensen of the Department of Sociology of Duke University; Dr. Harry Crane, North Carolina Commissioner of Mental Hygiene; Dr. John McCampbell, Superintendent of the State Hospital at Morganton, North Carolina; Dr. William W. Young, Atlanta (Georgia) psychiatrist; and Dr. George H. Preston, Commissioner of Mental Hygiene for Maryland.

The Mental Hygiene Society of Charlotte was organized by the board of directors of the child-guidance-clinic demonstration conducted under volunteer auspices in Charlotte from February, 1933, to October, 1934. The society then began a systematic, twofold program of educational and clinical work. The clinic now has two salaried workers—one part-time psychiatrist and one full-time psychiatric social worker—and is supported by the city department of health. The society holds monthly meetings and is emphasizing parental education, early diagnosis and treatment of nervous and mental disorders in children, and a better public understanding of the problem of mental disease as it exists in Charlotte and North Carolina.

The officers of the society are: *Honorary President,* Dr. William Allan; *President,* Mrs. Ernest B. Hunter; *Vice-President,* Mrs. John Tillett; *Secretary-Treasurer,* Rev. D. D. Holt; *Assistant Secretary-Treasurer,* Dr. Allyn B. Choate.

Oregon

An organized effort was initiated by the Oregon Mental Hygiene Society last spring to develop a state-wide, government-supported mental-health program, with special emphasis on its preventive aspects. The plan centers around the proposed establishment of a state psychopathic hospital tied up with the University of Oregon Medical School, and a state clinic service to grow out of the coöperative clinic now operating at the university for the benefit of the juvenile court and the public-school system in Portland. The project has been under advisement for some time by a special committee appointed by the governor to "examine into the feasibility, desirability, and cost" of the plan. Bills have been presented to the legislature, and the Oregon Society has embarked on a state-wide campaign of public education "which will be continued until the state sees fit to finance such an undertaking."

The society reports that problem children from the schools and wards of the juvenile court have been studied and treated at the child-guidance clinic of the University of Oregon Medical School for the last three years "with eminent success," thus "preventing the commitment of large numbers of children to the state institutions," and is urging the extension of this clinic service to every county in the state "as an authoritative, advisory, and treatment unit for a class of cases which at the present time are, in the main, miserably managed." So important is this as a preventive measure, according to the society, "that it should have priority in consideration of any expenditures in the general program of handling the mentally diseased."

Rhode Island

Twice the number of beds now provided for at the state hospital would be required to care adequately for the mentally sick in need of treatment in Rhode Island. While the public is beginning to appreciate the mental-health needs of the state, the financial support of a program to meet these needs, especially in their preventive aspects, is still negligible. Moreover, though the demand for mental-hygiene clinic services has increased during the past year, financial stringency has necessitated staff cutting and, consequently, a regretable curtailment of these services, which had reached a high point of development in recent years.

These were some of the high lights of a report on the year's work presented by Dr. Harold F. Corson, Medical Director, at the Rhode Island Society's annual meeting in Providence on April 15. Dr. Leonard Carmichael, president of the society, was chairman of the meeting, and Dr. Clarence M. Hincks, General Director of The National Committee for Mental Hygiene, gave the principal address.

The society, through its three clinics in Pawtucket and Providence, Dr. Corson said, treated a total of 417 children last year. Service was completed on 155 cases, and 152 new cases were accepted for study and treatment, each child requiring on an average fifteen interviews. "The demand for child-guidance-clinical service is very pressing," Dr. Corson reported, "and we cannot begin to care for the new applicants or give the necessary time to those who are already under treatment." Nevertheless, he said, the society continues to place emphasis on this phase of its work, "knowing that early recognition and treatment of personality and behavior deviations will not only enrich the life of the child, but will also minimize the possibility of later more serious trouble."

The psychiatric and mental-hygiene facilities of the state, he further said, are in many ways excellent, but there is tremendous overcrowding at the state hospital and the out-patient clinics work under a pressure that makes the best type of service almost impossible. To modernize and bring up to standard the state hospital at Howard would require, as a minimum, a five-year building program calling for an expenditure of six million dollars.

Another problem facing the society is the matter of extending its educational work throughout the state by the development of local committees such as have already been started in Westerly and Woonsocket. The society gets its financial support almost entirely from the Providence, Pawtucket, and Cranston community chests. An encouraging factor is the growing interest in the society's work reflected among contributors to the Providence Community fund, the last campaign reports showing an increase of 46 per cent in the

number of those designating the society in their gifts over the previous year.

"Mental health and education" was the topic of Dr. Hinck's address. While much remains to be done in strengthening diagnostic and therapeutic forces in the field of mental hygiene, a still greater need, Dr. Hincks said, lies in the direction of "increasing the efficiency of our instrumentalities for preventive work." Among the more potent of these instrumentalities he named the school, parent-teacher organizations, youth organizations, and recreational and adult-education forces. If these bodies took advantage of existing mental-hygiene knowledge and psychiatric insights concerning human behavior, he declared, an enormous contribution could be made to conserving mental health. Of all these forces he deemed the school a preëminent one, playing a vital rôle in personality development at the most plastic period of life.

Alluding to the thoroughgoing way in which European countries, for example Russia and Germany, are utilizing this instrument for social purposes, Dr. Hincks put this challenging question: "If we, here in America, believe that mental-hygiene aims are of supreme importance, why should not we use our schools to this end with the same zeal that other countries are using them for quite different objectives?" He then discussed some of the objectives and principles that should be considered in developing the school as an ally in mental-health endeavor.

> "The school should accept as its chief challenge," he said, "the development among children of robust personalities. . . . Specifically, we want the products of our schools to be human beings who can get along well with their fellows and who place group interests ahead of personal interests. We want our graduates to be trained in the assumption of responsibility. They should possess a wide range of interests. They should learn self-discipline. They should realize that life is a great adventure and that the very striving toward reasonable objectives brings great rewards. Full advantage should be taken in school of their capacities and aptitudes in cultural as well as vocational and technical training. They should develop good mental habits—for example, they should learn how to think through problems to their legitimate conclusion. . . .
>
> "Now suppose we accept some such listing of objectives as I have presented—socialization, self-discipline, and so on. What are the problems involved in developing our schools so that they can contribute effectively in this regard?
>
> "These problems might be discussed briefly under the headings of teacher selection and teacher training; school administration and curriculum; relations with the home; and the contribution of physicians and scientists.
>
> "There is no question but that the crucial element in a mental-hygiene program in schools is the teacher. Her temperament, her out-

look, her background of experience, the nature of her own adjustment, her capacity to hold the interest of her pupils, her knowledge of the mental-health needs of childhood, her academic qualifications—all are of supreme importance. It is, therefore, desirable that care be taken in her selection and training.

"A word or two about her selection. In addition to academic attainments, she must above all be a real person—a reasonably adjusted human being with a wide range of interests.

"Perhaps our schools have suffered from the fact that many of the finest teachers get married or leave this field of work for some other vocation; and the further fact that, of those who are not so good, many remain too long. It seems to me that unless a teacher remains youthful in outlook and can guard against becoming warped or soured or mechanized, indefinite tenure of office should not be assured.

"We cannot, of course, expect teachers always to remain fresh and inspiring if we in the community do not conspire to give them a reasonable chance to remain so. We should provide the teaching profession with every opportunity for varied, interesting, and normal living outside the classroom.

"In regard to teacher-training in mental hygiene, this involves the imparting of insights concerning the nature of childhood, concerning vital factors in child development, concerning mental-health needs of various kinds.

"Now, if a teacher recognizes the mental-health needs of children under her care, if she is able to size up each child from the angle of his strengths and weaknesses, then we can rely as a rule upon her own ingenuity in doing the right thing at the right time.

"In regard to school administration and curriculum, such factors as the following should be kept in mind: (1) arrangements for physical and mental examination; (2) training in line with capacity; (3) maintenance of interest; (4) extra-curricular activities; and (5) special services for the maladjusted.

"A word or two about these points. Physical and mental examinations should be made upon school entrance with arrangements for a continuous record throughout the school life. This is essential.

"Too much emphasis cannot be placed upon the principle of developing education programs that are in line with capacity of children. When this principle is violated—when we attempt to force children beyond their natural gait, when curriculum requirements are too difficult—then we may expect trouble.

"Another important point—the maintenance of the child's interest in his school work is a prime requisite. There is something wrong with teaching or curriculum or with the school arrangements if children lose interest. And if school means boredom, we can expect truancy, delinquency, retardation and, perhaps, neurotic patternings. One of my tests of a school—and I think it is a good test—is the degree of interest demonstrated by the pupils.

"Because of their great value for mental health in school and for adult life, extra-curricular activities should be as well provided for as classroom work.

"In one school system in this country wherein eighty thousand children are involved, there have been provided thirty recreational centers

with sixty directors and supervisors. Every day fifteen thousand children and five thousand parents are engaged in every conceivable form of avocational pursuit for the development of skills and other satisfactions. And when a child is not taking part, he becomes an object for special study and special training.

"The work in this particular school system has appealed to me because of my belief that many children do not become socialized due to the fact that they have never learned how to play, or have never been trained in skills involved in hobbies. They, therefore, become sensitive and seclusive, and avoid group activities.

"In any school system, no matter how excellent, we can expect a certain proportion of children to develop more or less serious behavior and personality problems. And for such we need special mental-hygiene services with capable counselors.

"Now a word about relations with the home. A mental-health program for children will fail if parents and the home are left out of consideration. I have known constructive efforts in the school to go for naught when parents were uncoöperative. Hence the necessity for tie-ups through visiting teachers and through parent-teacher associations. Indeed, I hope the day will come when schools will sponsor parent-education programs in child-rearing as a regular part of their activities.

"The last point I will touch upon is the contribution of physicians and scientists. There is no question but that an enormous impetus could be given to the development of education along mental-health lines by a partnership between educators and those who have been giving special thought to the problems of human behavior. And I believe that the time is now ripe for such partnership."

Educational Diagnosis

The mental-health aspects of "educational diagnosis" were discussed by Dr. George S. Stevenson at a conference of the National Society for the Study of Education held in Atlantic City last February. Taking as his topic "The Cultural Significance of School Failure," Dr. Stevenson described educational diagnosis as a phase of growth which reflects not merely an internal scientific evolution within the field of education, but also an increasing concern with the various social and community forces that influence child development and the integrative values derived from other professional fields that are contributing to and supplementing the work of the schools. He then traced some of the factors responsible for the growing preoccupation with school failures as a major problem that calls for fundamental and radical treatment.

School failure, Dr. Stevenson said, has become intolerable because it represents a major social burden comparable to delinquency, mental disease, and crime in its immediate costs to the public, and because it is intimately related to these other major problems. "When we add to these costs the fact that failure alienates public support

of education, is destructive to the personality development of the child in a labile period, and deprives the child himself of time and creative opportunity, the effects are stupendous and far-reaching. Moreover, when we appreciate that failure is merely the obvious phase of a loss that exists in latent form among all of those who pass with less than the maximum development of potentialities, the effect in retarding cultural advance is very likely to be even greater." Hence, education is advancing from techniques that were distinctly remedial to those designed to lead to a more positive development of its opportunities. Hence also the step from a "single pattern" of education, applied for the benefit of the greatest number, and sacrificing the rest to failure, to a "generalized pattern" of education which recognizes individual variation and seeks through thoroughgoing diagnostic and remedial work to prevent failure and develop potentialities in every individual. The school is, therefore, logically forced to abandon its isolation and autonomy in the community and instead of confining its diagnostic effort to a series of examining procedures conducted within the school budget and under school authority, must join forces with the health, welfare, recreational, protective, and other integrating community forces.

Applying some of the lessons learned from the experience of medicine, and more particularly psychiatry, to the problems that face the schools in developing sound diagnostic and remedial procedures, Dr. Stevenson mentioned especially the doctrine of multiple causation and its peculiar significance for the study of child behavior, as well as the emphasis on social factors and on the element of personality, both in the teacher and the pupil, as against mere laboratory technique. "If there is any validity in the idea that educational diagnosis must involve many extrinsic features, and if the interest in the personal relationship between teacher and pupil or administrator and teacher is more than a vogue, then educational diagnosis cannot ignore the mental health and personality make-up of the teacher and student teacher any more than the hygienist can ignore the health of the food handler."

Vocational Placement in Psychiatric Social Work

The National Committee for Mental Hygiene, whose interest in standards of psychiatric social work is of long standing, has been coöperating for a number of years with the Joint Vocational Service, national non-profit-making placement agency for social workers and public-health nurses, in filling psychiatric-social-work positions in clinics and hospitals throughout the country. Recently, this coöperative relationship has been established on a more formal basis, so that it now corresponds in general with that already existing between the

Joint Vocational Service and the Family Welfare Association of America, the National Organization for Public Health Nursing, and various similar agencies.

Under the new arrangement, requests from employers and from applicants for placement may be addressed, as formerly, either to The National Committee for Mental Hygiene or to the Joint Vocational Service. It will be understood, however, that all requests not referred in express confidence to one or the other agency will be handled routinely in consultation, and that the required fee for placement will be collectible by the Joint Vocational Service. The National Committee for Mental Hygiene will bring to bear its knowledge of individual workers, local possibilities, and desirable standards, while the Joint Vocational Service will make available its highly pertinent experience in placement and its exceptional file of personal records on personnel.

Residencies in Psychiatry

Applications are now being considered for two assistant residencies in psychiatry at the Cincinnati General Hospital. The positions are open to graduates in medicine who have had a one-year interneship in a Class A hospital.

The service affords a wide variety of practical experience with psychiatric problems. The service is an active one; there is a bed capacity of sixty-five, with an admission rate of about one hundred and twenty cases per month. A large number of the admissions are acute cases and diagnostic problems, including many in which internal medical and surgical factors play an important rôle. In addition, facilities are available for observation and treatment of a group of patients over a period of several months. Consequently, experience with many aspects of psychiatric cases, acute and chronic, organic and psychogenic, and their diagnosis and treatment (physical and psychologic) is available.

The hospital psychiatric service is intimately connected with the Medical School of the University of Cincinnati. The house staff will have the opportunity, therefore, of attending a large number of clinical demonstrations and theoretical lectures.

The routine laboratory work will be done by medical students.

Appointments will be made for one year, one beginning July 1, 1935, and one beginning January 1, 1936. Compensation includes $300.00 a year and complete maintenance.

Applications should be addressed to E. A. North, M.D., Director, Department of Psychiatry, Cincinnati General Hospital, Cincinnati, Ohio.

New Project for the Study of Nervous and Mental Disorders in Children

A new Division of Child Neurology, made possible by an endowment from the Friedsam Foundation and designed to become a center of research for the study and treatment of nervous and mental disorders of childhood, was announced recently by the board of trustees of the Neurological Institute of New York, with which the new division will be affiliated.

Dr. Bernard Sachs, recent president of the New York Academy of Medicine and eminent neurologist, is director of the new unit. "The main purpose of the formation of a Division of Child Neurology is the establishment of a real center of research for the nervous and mental disorders of childhood," Dr. Sachs said. "It is in my own particular field and I am especially anxious to see such a center established to further the exhaustive study of the early nervous disorders of children. I consider it one of the most important tasks in preventive medicine to find out all we can about the nervous disorders of childhood so that we may be able to discover and develop the proper treatment."

One of Dr. Sachs's associates in the new unit is Dr. Frederick Tilney, brain specialist, professor of neurology at Columbia University and director of the Normal Child Development Clinic operated by the Neurological Institute at the Columbia-Presbyterian Medical Center. He will be associate director in charge of research.

Ultimately, Dr. Sachs said, it is hoped that there will be a fusion in one center or unit of all departments at the Medical Center that have to do with the early mental development or nervous diseases of children, including the Normal Child Development Clinic.

In order to encourage research work in the mental disorders of children, a weekly seminar will be held by the new unit under the chairmanship of the director. All members of the staff will be expected to attend and to present patients and special subjects for discussion, and all physicians interested in child neurology will be welcome at these weekly seminars.

A comprehensive research program has already been drawn up, including study of the following subjects:

1. Convulsions of childhood, including the epilepsies.
2. St. Vitus dance and all other choreic manifestations, also all forms of tics and convulsive spasms.
3. Intensive study, proper treatment, and after-care of all forms of infantile paralysis.
4. The relationship of the internal glands to various infantile nervous disorders.

5. The birth palsies, cerebral and spinal, in which, it was pointed out, affiliation with the Birth Injury Clinic will be of great importance.

6. The problem of retarded brain development.

7. Study and treatment of speech defects of organic and functional origin.

8. All forms of encephalitis (including sleeping sickness) and meningitis.

9. All forms of brain and spinal tumors.

10. All forms of progressive muscular atrophies and dystrophies.

11. The behavior disorders of children.

"The study of these diseases," says the formal announcement, "is to be based first of all upon a very thorough understanding of the basic organic and structural conditions. For that reason, a very close affiliation with the Babies' Hospital will be maintained by the appointment of an attending pediatrist to the staff of the Division of Child Neurology. For the careful study of mental conditions in children there is to be a close affiliation with the Psychiatric Institute. All these institutions have intimate relations with the College of Physicians and Surgeons and with the entire Medical Center. The creation of this new Division of Child Neurology will, it is hoped, act as an incentive to further research in this and other divisions of the Neurological Institute."

In addition to Dr. Tilney, the following appointments to the staff of the Division of Child Neurology were announced: Dr. Louis Casamajor, associate director; Drs. L. Beverly Cheney, Walter Klingman, attending neurologists; Dr. Howard W. Potter, attending psychiatrist; Dr. Howard R. Craig, pediatrist; Drs. Robert W. Laidlaw, S. Muriel Barron, assistant neurologists; and Dr. Earl R. Carlson, chief of Birth Injuries Clinic. Later an orthopedist and a psychologist will be added to the staff.

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